Neglected Dimensions in Health and Healing

Study Document No 3

Concepts and Explorations in an Ecumenical Perspective

DIFÄM
German Institute
for Medical Mission

Neglected Dimensions in Health and Healing

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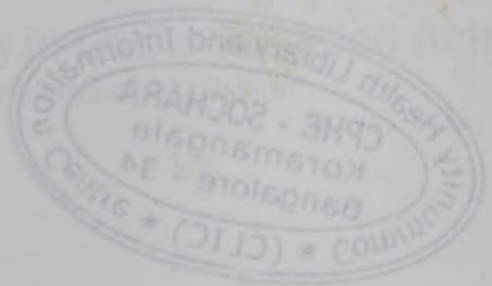
in an Ecumenical Perspective



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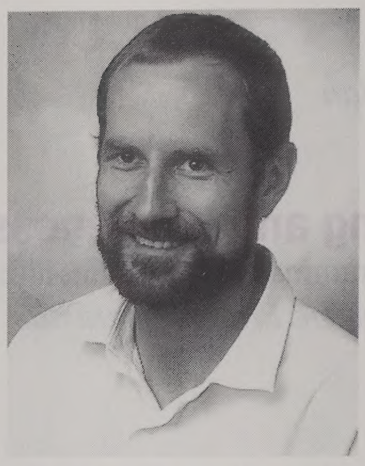

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Appreciation

Many people have contributed to the translation of the original study document "Die vernachlässigten Dimensionen" into English. We would like to thank very much our committed co-workers in DIFÄM Mrs. Rätzke-Werner and Mrs. Scaal for their excellent contribution.
In particular we would like to express our deeply felt gratitude to Prof. Troy W. Martin of St. Xavier University in Chicago. He not only helped with the translations but also gave invaluable advice and comments to facilitate the understanding of ou concepts for English speaking readers.
In addition we would like to thank Dr. Dietma Schicketanz and Prof. Eberhard Winkler who hav contributed very much to the ecumenical discus sion on health, healing and wholeness and wh have influenced our understanding of the multidi mensional nature of healing. The title of this study document draws on the doctoral dissertation o Dietmar Schicketanz that was published in 1992.

Preface

Mutual understanding and good cooperation will always and decisively depend on successful communication. This is as well true for the ecumenical process where sometimes highly abstract and complex questions are being discussed. This DIFAEM study document is meant to be a contribution to a fruitful ecumenical study process on the "ministry of healing and reconciliation".

The German Institute for Medical Mission (DIFÄM) can look back at a long tradition in this field, as will be explained in the article on "Health, Healing and Wholeness". The Tübingen Consultation in 1964 was an important milestone not only for our Institute, but also for the self-understanding and identity of many church-related health services all over the world. Today we are called to reflect upon the ideas of that time again. How can they be put into practice in our time? Several contributions in this study document therefore try to give a present-day interpretation of questions that had been discussed intensively in 1964 and that are still playing an important role in the ecumenical discussion, like: What happened to the churches' mission to heal? How can communities become healing communities? Which contribution can Medical Mission make towards a better health of people worldwide?

No article can claim to express "the truth". We only want to discover God's truth, receive it within our hearts and translate it into our daily life – also with regard to our commitment for better health and for those who are sick or even terminally ill.

Without any doubt it is a gift of God if somebody is healed or given the capacity and patience to endure suffering, and those who contribute to this certainly take part in building God's Kingdom. We must understand this unique gift of God more deeply.

Within the different articles it is impressive to discover the truth of Christ's word "The words I have spoken to you are both spirit and life." They are true with regard to our own health, to the community's well being and also to the global co-existence of different people and cultures.

The scientific findings as described in the contribution "Does faith contribute to healing?" suggest that a living faith can have an enormous effect on health. Twenty years ago, this theory would have been rejected with a sneer and interpreted as another inappropriate effort to prove the existence of God. We do, however, not want to construct evidences of God – God does not need any human evidence –, but we want to promote the fullness of life.

Paul Tillich's and Viktor Frankl's anthropological models have been of great help to the DIFÄM-study process. In many aspects the idea that the different dimensions of human life are always interacting with each other and that man's healing relationship with God must in no way be understood as to be competing with modern medicine or any health care system – this idea can only be understood fully and in all it's depth if there is – in human terms – no more hope.

The hope founded in God never comes to an end. – May the present study document help that this truth is better understood and put into practice, especially in our European culture!

Rainward Bastian
– Editor –
Director of the DIFÄM

Health, Healing and Wholeness

Concepts and Programmes in the Ecumenical Discussion

Christoph Benn and Erlinda Senturias

Many Christians worldwide are concerned about the questions of health and healing, the involvement of the churches in the provision of health care services, and about the relationship of health and faith in Jesus Christ. Healing movements are part of the Christian witness not only in charismatic communities but also in many mainline churches. These movements are most prominent in the churches of Africa, Asia and Latin America. Nevertheless, churches in other areas of the world such as North America and Europe cannot afford to neglect the scores of people who desire concrete experiences of the gospel and seek a church that responds in an holistic way to their physical, mental and spiritual needs. This Christian concern about health raises many theological, medical and cultural questions that require clarification.

A review of the rich ecumenical discussion on health and wholeness can clarify some of these questions. One of the most significant developments in this discussion was the consultation organized by the German Institute for Medical Mission in Tübingen in 1964. This consultation led to the creation of the Christian Medical Commission (CMC) of the World Council of Churches (WCC) in Geneva. Following this consultation, several studies on the relationship betwee health, faith and the Christian understanding of healing have been conducted. The CMC also generated a nun ber of conferences and study groups a over the world. The present article provides a review of the ecumenical discu sion on health, healing and wholeness and gives an overview of the most rele vant conferences and publications of th last decades.

1 Historical developments in the ecumenical discussion

Healing was a central feature of Jesu ministry. The apostles and the early churc continued the ministry of healing but th practice of healing and its theological inte pretation within the churches changed aft a few centuries. The church and its mona teries concentrated more on charity, ar care for pilgrims and the sick rather tha on healing in a medical sense. The mo fundamental change occurred with the a cent of science, technology and medicine i the 19th century. New discoveries and de velopments equipped medicine with effe tive means to cure diseases, and the churc with new possibilities for rediscovering i healing ministry. As the knowledge about e fective healing methods increased, Chris tians felt a moral duty to make availabl these opportunities to all people in need.

In the same way, many of the newly ounded missionary societies felt that there vas a duty to provide healing for the sick in he countries where they were operating. Before the middle of the 20th century, the ocieties had founded hospitals, dispenaries and leprosariums all over the world. These establishments supplied scientifically ased medicine and contributed signifiantly to the health care systems of many ountries. At present, church-related instiutions provide up to one half of the hospial beds in some African countries.

Several motivations led to the Christian ngagement in health care.[1]

- First, the strategy of the missionary soieties encouraged the founding of hospials. These societies perceived that health are institutions could reach many people or the gospel. The effectiveness of the healng methods supported the credibility of the roclamation of the Word.
- Second, Christian charity contributed o the construction of hospitals. Healing of he sick was seen as a sign of charity and of ersonal commitment to help the people most in need.
- Third, the health of the missionaries hemselves prompted the creation of hospials. Especially at the beginning of the hisory of medical missions, an important moivation to create health care institutions was the need to protect the health of the missionaries who suffered from many diseases unknown in their countries of origin.
- Fourth, the imitation of Christ motivated these missionary societies to found hospitals. The healing of people suffering rom diseases was considered a direct exression of discipleship. Jesus Christ himself had cared for the sick and the weak in a very particular way, and he had sent his disciples to proclaim the gospel and to heal the sick (Matthew 10:1 and Luke 9:2).

Jesus' double commission to preach and to heal was practised in missionary areas overseas, whereas in the Western countries a division of labour had emerged whereby physicians were responsible for the body, and theologians for the soul. For overseas missions, this dichotomy was impossible because it did not correspond to the indigenous cultures and philosophies of people who adopt a more holistic or multidimensional view of the human person. To combine the two aspects of this dichotomy, therefore, many missionaries received some kind of medical training, and many medical missionaries were sent to theological colleges.

There are two different models of and justifications for the healing ministry of the church. One model promotes caring for the sick because of charity.

This model shaped by the example of the Good Samaritan is congruent with a division of the human person into the body for which medical science carries the responsibility, and into the soul for which pastorally trained theologians provide spiritual care. By and large, churches in European countries such as Germany practise this model.

The other model follows the healing ministry of Jesus more closely and takes a holistic approach to healing.

1 Grundmann, Gesandt zu heilen, 1992.

The human person represents a unity of body and soul so that all healing methods have to be multidimensional. This model enables those with both medical and theological qualifications to exercise a more comprehensive healing ministry. The model is Jesus himself as a healer. Many health care institutions of churches in Africa, Asia and Latin America, as well as holistic healing centres of some churches in Western countries, practise this model.

The medical work of missions had its most active phase in the years after world war I. At that time, the Protestant churches alone supported around 2100 hospitals and many more clinics all over the world.[2] After world war II, however, changing conditions required a new reflection on the churches' engagement in health care. Some of the questions and problems that arose as a result of these changing conditions were as follows:

- Many countries in which mission societies were active gained independence. They developed a new consciousness as nations and resisted domination by foreign organizations. Independent national churches were founded and took over many of the institutions of the mission societies, such as hospitals and schools.

- Many independent nations built government hospitals, and some missionary institutions were nationalized. These developments made the status of medical missions unclear. The churches were unsure whether or not to let the governments take over the whole health care system. The churches had to face the issue of whether or not there w a specific Christian ministry of healing a how to define this ministry. They also had articulate the differences between a gover ment and a church hospital.

- The cost of maintaining hospitals i creased dramatically with technologic progress. The newly founded independe churches were not able to maintain the institutions alone but nevertheless had find ways to reduce their dependence foreign missions and partners.

- In spite of enormous expenditur only a minority of people could be reache through hospital based health care. In th newly independent countries, only about 2 percent of the population had access Western type hospitals whereas the remai ing 80 percent lacked modern health car Furthermore, studies showed that povert malnutrition and a lack of hygiene and san tation caused many of the diseases prev lent in these countries. Hospitals were ine fective in addressing these causes.

These changing conditions were unse tling to the churches and missionary soci eties and posed serious challenges to th further development of church-relate health care. Increasingly, people wondere how missionary hospitals and the prevalen strategy of medical missions could be re conciled with the Christian understandin of justice. Based on some preliminary stud ies, the WCC and the Lutheran World Feder ation (LWF) called for a consultation to ad dress the changing conditions of medica missions. This consultation was held in th German Institute for Medical Missions i Tübingen in 1964 and became known a Tübingen I.

2 McGilvray, The Quest for Health and Wholeness, 1981, p.

Tübingen I

The participants at this consultation reached conclusions that provided answers to many of the questions raised by the changing conditions of medical missions. This consultation resulted in a rethinking of the strategy of medical missions and in a new foundation for the Christian healing ministry. The participants in Tübingen I formulated answers to burning questions, and both the newly founded independent churches and the mission societies themselves received the results very positively. Even today, many churches in Africa and Asia feel that the conclusions of the Tübingen consultation deeply influence their work in health care. In addition, Tübingen I led to the creation of the CMC of the WCC in Geneva. Even the participants in Tübingen I were surprised by the unexpected accomplishments and the spirit among themselves that led to commonly agreed conclusions.

The following is an excerpt from a document entitled "The Healing Church", which states some of the more pertinent conclusions of Tübingen I.

II. The Christian Concept of the Healing Ministry

1. The Christian Church has a specific task in the field of healing

This is to say more than simply that the Church has a duty to support all that contributes to the welfare of man.

It is to say that there are insights concerning the nature of health, which are available only within the context of the Christian faith. The Church cannot surrender its responsibility in the field of healing to other agencies. This, however, leaves entirely open the question whether, in a given situation, the Church best discharges its duty in the field of healing through the maintenance of hospitals, clinics and similar institutions with their medical teams, or through the work of Christians in secular institutions, or through a combination of both.

2. The specific character of the Christian understanding of health and of healing arises from its place in the whole Christian belief about God's plan of salvation for mankind

The Christian understanding of healing begins from its place in the ministry of Jesus. There it was a sign of the breaking into human life of the powers of the Kingdom of God, and of the dethroning of the powers of evil. The health which was its fruit was not something static, a restored equilibrium; it was an involvement with Jesus in the victorious encounter of the Kingdom of God with the powers of evil.

3. The Christian ministry of healing belongs to the congregation as a whole, and only in that context to those who are specially trained.

If healing is understood as above, it will be clear that the entire congregation has a part to play in it. By its prayer, by the love with which it surrounds each person, by the practical acts which express its concern for every man, and by the opportunities which it offers for participation in Christ's mission, the congregation is the primary agent of healing. At the heart of this healing activity lies the ministry of the Word, Sacraments and prayer. The specialized work of those

who have been trained in the techniques of modern medicine have their proper place and will be fruitful in the context of this whole congregational life.

III. The Role of the Congregation in the Ministry of Healing

2. All healing is of God.

This is so whether or not it seems to occur through what we call natural laws – some of which we know, whether or not it appears to have been brought about by what we call medical means, or whether or not it has been accomplished by means of spiritual healing.

This should be accepted even to the extent that all the achievements of modern medicine ultimately are to be understood as signs of the healing power of God.

For this very reason we accept modern medicine as a gift from God and use with the same gratitude both the spiritual and the scientific means of healing.

Quoted from: WCC – The Healing Church, pp. 34-36.[3]

In spite of their positive reception, widespread implementation and far-reaching influence, the conclusions reached at Tübingen I did not escape some criticism in the ensuing discussion. The following issues were of particular concern:

• Tübingen I stated that the church h a specific task in the field of healing. It h certain insights into the nature of heali that can only be gained in the context Christian faith. Therefore, the church ca not surrender the responsibility in the fie of healing to other organizations such the government. This statement requir qualification in the light of the principle subsidiarity. It implies that the primary r sponsibility for the health care of people r mains with the governments of nations. Th churches are not in a position to provi this kind of care either financially or pr fessionally. The churches, however, try complement government services whe these cannot fulfil their commitments when there are particularly disadvantage people for whom nobody cares. Holding th churches primarily responsible for healt care on a national scale would be a misu derstanding of the church's mission.

• Tübingen I interpreted healing as sign for the beginning of the kingdom God and of the dethroning of the powers evil. This understanding of healing migh sound triumphalistic, and corresponds to particular model of mission that restrict the experience of salvation and healing to relationship with Jesus Christ. This mode confines salvation within the Christia churches as legitimate followers of Jesu Christ. This interpretation of Tübingen leads to questions about the definition healing and about the theological relevanc of healing in non-Christian institutions. Th theologian Ulrich Bach[4] has been con cerned that the close connection betwee health and salvation through Jesus Chris

3 WCC, The Healing Church, 1965.

4 Bach, U., Heilende Gemeinde?, 1988

ight lead to a discrimination of sick peo-
le. They might feel that if they cannot be
ealed they would not be part of God's
race. He correctly observed that several
erms used at the Tübingen Consultation
uch as health and healing were insuffi-
iently defined, and that these vague defini-
ons led to some misunderstandings in the
ter use of the consultation's documents.
le pointed out that the interpretation of
ealing as the dethroning of evil could lead
a dangerous correlation of disease with
vil powers and with God's punishment.
herefore, people should neither under-
tand disease as a sign of the absence of
od nor understand health as a precondi-
ion for salvation. Tübingen I did not inten-
ionally discriminate against anyone or re-
ard disease as a punishment of God. But
ertainly the ensuing discussion empha-
ized the need for precise terminology to
void similar misunderstandings in the fu-
ure.

- If healing is defined in a holistic way
nd is viewed as a concrete sign of the king-
lom of God, then misunderstanding can be
voided. Healing need not be restricted to
hristian initiatives, and disease can be
een as a sign for a world awaiting salvation
without making the individual patient feel
hat suffering is inflicted by God. In this
ense, healing represents the defeat of
ranspersonal evil powers that contradict
he original good intention of God for all
uman beings.

- The concept "healing community"
as a central theme of Tübingen I and em-
odied an ideal that inspired many congre-
ations in Asia and Africa to integrate the
oncept of a healing community with the
rinciples of community based health care.

In Germany and other industrialized nations, however, the reception of this concept was difficult. Many theologians regarded the obligation to create healing congregations as too difficult and the theological elevation of healing as inappropriate. They suspected that this concept introduced spiritual or charismatic healing in contradiction to sound medical science. These theologians did not relate the concept "healing communities" to holistic healing that churches could indeed support even in industrialized countries. There was, and still is, a lack of awareness of the empirical evidence for the important contribution of spirituality and religious communities to health.

3 Tübingen II

Tübingen I initiated an important discussion that had to be continued within the ecumenical movement. For this purpose, another consultation was organized and held in Tübingen in 1967. To simplify matters, this consultation was later named Tübingen II. The main issue of this consultation was the further clarification and precise elaboration of the theological statements that had been worked out in the first consultation. The preparations as well as the conference itself were strongly influenced by Robert Lambourne, a British physician and theologian who had written a remarkable book entitled *Community, Church and Healing*.[5] In this book, Lambourne emphasized that healing has to do not only with a sick individual and his or her healer but also with the community or society in which disease and healing occur. He explained his

5 Lambourne, Community, Church and Healing, 1963

ideas by quoting from the Old Testament, which treats the individual person as less important than his or her family or clan. According to Lambourne, even stories about healing in the New Testament that apparently recount Jesus' care for individuals actually present these individuals as representatives of the whole group of the sick and suffering. Jesus' healing ministry points to the forthcoming kingdom of God, and in this context the onlookers and the witnesses of an act of healing are concerned as much as the person that is healed. The crowd has to make a choice either to read the signs of the times and recognize Jesus as the Messiah or to ignore this reality.

Lambourne's contributions exemplified how this consultation laboured over some of the theological issues to achieve more insight about the importance and relevance of healing communities. In contrast to Tübingen I, this second consultation was not so much a breakthrough that led to completely new insights, as a demonstration of the difficult task that lay ahead in formulating the theological and practical implications of the new understanding of health and healing. The need for continued close cooperation between the disciplines of medicine and theology became apparent. Therefore, Tübingen II decided that these issues needed more work and took steps to establish a new department of the WCC.[6]

This resulted in placing health and healing on the agenda of the Conference on World Mission and Evangelism, which then became the sponsoring agency for the creation of the Christian Medical Commission (CMC) in 1968. In that year, the fourth a sembly of the WCC in Uppsala gave a fi year mandate for CMC to search for new i sights into the interconnection betwe healing, the gospel and the mission of t church.

A wide door of opportunity for shapi the future of health and healing ministry the ecumenical movement was opened u The enthusiasm for a new and relevant di course on health was evident in the sm group of staff and the newly appoint members of the commission.

4 The Christian Medical Commission

The first meeting of CMC took place Geneva in September 1968. A stateme came out of that meeting defining the co mission's understanding of its tasks:

1. to help the churches in their searc for a Christian understanding of health a healing;

2. to promote innovative approaches health care;

3. to encourage church-related heal care programmes to collaborate with eac other.

The commission meetings served as think tank group for the cutting edge issu in health and healing that churches a challenged to address. Some meetin opened with a dialogue between the mode ator, Dr. Jack Bryant, a public health expe from the USA, and the theologian Dr. Davi Jenkins, a member of the WCC Staff co ducting *humanum* studies, and late Bishop of Durham. The famous Bryan Jenkins debate highlighted the following is sues:

6 DIFÄM, Health. Medical-Theological Perspectives, 1967.

1. Making moral decisions

a) What can the discipline of theology offer to physicians who have to make life and death decisions about priorities in health care?

b) What are the theological concepts that will give the decision-makers a system of human values to fit with the technological methodologies?

c) Can the churches develop a social morality of health care that might be of use to governments and secular institutions?

2. Looking at the value of human life in relation to ethical decisions

a) Of what value are those lives we are deciding about?

b) What is human life for?

c) How are human values to be brought into the framework of technology?

d) What does it mean to be responsible for the health of 100,000 people in an area and to have to make choices between treatment and prevention?

3. Health care and justice

a) Is there such a thing as "statistical compassion", and what is its theological equivalent?

b) In the face of politics, power and the injustices inherent in human systems, how far down the road is it appropriate to go?

c) What hope is there if the dice are so loaded?

We take note of three important phrases to hang on to, as suggested by Dr. Jenkins: "the hopefulness of solidarity in sin", "the non-utopian nature of impossible hopes", and "the possibilities of the infinite in the finite". The hope for humanity lies in their ability not to be trapped by institutional problems but to become persons who are free to re-identify and help others to become such (Bryant and Jenkins[7]).

The debate appeared in *Contact*, a publication that CMC started in November 1970. The periodical was directed at health workers, and served as a vehicle for promoting innovative approaches to health care. *Contact* contained both articles about ethical values and practical examples from the field of community action to solve health problems. The seeds planted by *Contact* served as an inspiration to those beginning to question the relevance of health ministries in the post-colonial and neo-colonial period.

5 Primary Health Care

The early efforts of the CMC led to what became known as primary health care (PHC).

Observing that in some countries a single university medical training institution consumed as much as 80 percent of the country's health care budget, the CMC sought to create primary health care systems by decentralizing the training of health care workers and the delivery of health care itself. Encouraged by the CMC, Christian communities began to train village health workers at the grassroots level. Equipped with essential drugs and simple methods, these workers were able to treat most common diseases and to promote the use of clean water and better hygienic conditions. They facilitated the introduction of small health centres that offered low cost in-pa-

7 Bryant, Moral Issues and Health Care, 1971

tient care, as well as prenatal and early childhood health services. In these new decentralized health care systems, district hospitals began to play an essential role by acting as intermediaries between local village health services and the centralized state supported hospitals.

Many existing mission hospitals took the function of district hospitals and began to play this essential integrative role in the new decentralized health care systems promoted by the CMC in the journal Contact.[8]

The "barefoot doctors" in China did not go unnoticed as an example of a paradigm in health care. The seeds of people's participation was affirmed in the Chinese poem:

Go to the people, live among them, learn from them, start with what they know, build on what they have. But of the best leaders, when their task is accomplished, their work is done, the people all remark, "We have done it ourselves."

In many continents, new ways of transforming health were taking place through social analysis, the praxis of action-reflection-action, changes in pedagogical methods such as the conscientization methods employed by Paulo Freire in Brazil, and training for transformation applied in communities in Africa.

Another pioneering work in this period was the collaboration with government and inter-governmental organizations like the World Health Organization (WHO). Th early beginnings of CMC supported the cr ation of more effective national structur for Christian medical work. Coordinati agencies for church health work were e tablished. These bodies pressured gover ments to grant import duty exemption voluntary agencies, worked for cheap pharmaceutical supplies through bulk bu ing, provided a platform for influenci government and other non-government organizations, and lobbied governments o political issues. As much as possibl Protestant and Catholic health agenci joined to form ecumenical organization thus avoiding duplication and competitio and to work together on the training of pe sonnel.

CMC was mainly an enabling and sup porting body to the coordinating agencie It did not provide funds for the work at th national level. An important function wa the collaboration with the WHO. In Marc 1974, the CMC-WHO collaboration was fo malized. In 1975, the staff members of CM were called to participate in the formulatio by WHO of the principles of primary healt care. Many of the case studies on prima health care published in the landmark stud "Health by the People"[9] originated from th CMC network.

The important work in the five years o being a sponsored agency of CWME was ex tended until the fifth Assembly of the WCC i Nairobi.

8 WCC, The Principles and Practice of Primary Health Care, 1979

9 Newell, Health by the People, 1975

6 From Nairobi to Vancouver (1975-1983)

The WCC Nairobi assembly gave a fresh mandate to CMC to continue its work but located the concerns in the newly created programme unit II – Justice and Service. The WCC central committee mandated CMC to serve as an enabling organization to churches everywhere as they searched for an understanding of health and healing which is distinctive to the Christian faith. A study on health, healing and wholeness was commissioned to explore insights into and provide theological reflections on the Christian understanding of life, death, suffering, and health so that this may find expression in churches' concern for health care and healing communities. Rather than engaging in an academic discussion, CMC decided to carry out the study in several regions of the WCC.

Meanwhile, CMC was closely involved by the World Health Organization (WHO) in the planning for the International Conference on Primary Health Care in Alma Ata in September 1978. The slogan "Health for All by the Year 2000"[10] was coined around this period and there was a lot of hope.

It was expected that primary health care would become self-sufficient within a few years. Early on, CMC commissioned a study to identify the factors that influence the financing and costs of community based health care, and to see how they operate in selected local programmes. The study also aimed to identify the principles of good practice, which PHC programmes had learnt from experience, and to distil them in such a way that new initiatives could learn from them. It was discovered that accurate bookkeeping and records were virtually absent in PHC programmes. The ethos of PHC, with its insistence on participation and appropriateness, had an in-built resistance to conventional economic analysis. Later, one realized that, when governments implemented PHC in the top-down approach, the principal methodology was compromised and contributed to the failure to achieve the goal of health for all.

7 Study on Health, Healing and Wholeness

The study on Health, Healing and Wholeness began in 1979 and ended in 1988. It was a good period for disseminating and validating the concepts of primary health care as stated in Alma Ata in 1978. At the end of the seven-year period from Nairobi to Vancouver, the studies had mainly taken place in the developing regions. In the Caribbean, in Central and South America, the study highlighted structural injustice as an impediment to health. On the African continent, African spirituality and traditional healing practices emanating from such beliefs were highlighted as an important factor for healing. In Asia and the Pacific, the study consultations emphasized the pluralist, multi-faith context and the traditional medicines emanating from various faith traditions, such as the Unani medicine of Islamic tradition, Ayurvedic medicine of Hindu tradition, and indigenous practices of various ethnic and aboriginal groups. Indigenous healing systems were cosmic and ancestral and Supreme Being spirit-cen-

10 WHO, Primary Health Care, 1978

tred, in contradistinction with the Western mode of healing introduced during the colonial period. Structural injustices were also highlighted as an impediment to the full implementation of primary health care as experienced for example in the Philippines. In all the regions, it was evident that there was a close relationship between healing and salvation. A CMC definition of health emphasized the dynamic relationship among human beings, the Creator, and the rest of creation. Right relationship promotes wholeness and salvation. A Bossey Consultation in 1979 on Death and Dying was organized as part of the study process on health, healing and wholeness.

The study from the perspective of the North demonstrated another dimension of health, healing and wholeness. The lack of community spirit was recognized as a problem in Northern countries. The title of the European report was very relevant: *Who Lives, Who Dies, Who Cares?*[11] A Swedish participant commented: "We are looking for love in the midst of all this damned security." Loneliness was a feature of socialist countries in Eastern Europe where the state took responsibility for basic needs, and people did not need to help each other. Inter-dependence was an important value. In Hong Kong the leading causes of illnesses were not communicable diseases but injury, poisoning and cancer. The same was and is true for North America and Europe. In the midst of sophisticated technologies emanating from the Western medical world, a call for congregations to become healing communities has been pursued by enlightened church and health people in the USA. The parish nurse movement and various hea movements within the church contribut to developing healing communities.

An interim report on the study was pr sented to the 1981 central committee of t WCC, meeting in Dresden.[12] The repo noted the close relation between heali and salvation, and was given prominence the report of the general secretary, I Philip Potter to the delegates of the sixth a sembly in Vancouver in 1983.[13]

Parallel to the initiatives of the CMC, the German Institute for Medical Mission or ganized the Study Advisory Group, an other initiative devoted to a deeper un derstanding of the Christian mission o healing.

In this study group, theologians and phys cians from various countries met regular from 1976 to 1981. James McGilvray, wh had been the first director of the CMC, hel this group together and published the re sults of the proceedings of this group in book by McGilvray, entitled *The Quest fo Health and Wholeness.*[14]

This book provides an outline of the en tire history of the Christian healing ministr from early Christianity to the present. Th reflections on the current situation in healt care systems begin with a critique of the so called medical model. Scientific medicin assumes a dominant role in many societie that adopt this model. People in these soci eties place high hopes in modern medicin

11 WCC, Who lives, Who dies, Who Cares? 1987

12 Potter, Report of the General Secretary, 1981
13 Gill, Gathered for Life, 1983
14 McGilvray, The Quest for Health and Wholeness, 1981

and its representatives. They expect more from these modern priests and prophets than the cure of their diseases. The expectations and hopes placed in medicine easily assume a religious character. Dr. David Jenkins, who had been an active member of the Study Advisory Group from the beginning, even spoke of the worship of medicine as an idol by many. In contrast to such an understanding of medicine inherent in the medical model, McGilvray's book proposes an alternative understanding of medicine that arose in the Study Advisory Group and the CMC meetings. In this other model, medicine is aware of its limits and realizes that even in industrialized nations, the financial means for high-tech medicine are not unlimited and some kind of rationing is necessary. This rationing is even more necessary in developing countries, which cannot afford to provide access to expensive modern health care for everyone. In addition to adopting the principles of Primary Health Care, therefore, modern medicine needs to replace its mechanistic and compartmentalized conception of the human person with a holistic conception.

The results of the Study Advisory Group demonstrate that medicine must not only abandon the separation of body, soul, and spirit but must also understand the human person as a being in relationship to other persons, to the environment and to God.

8 From Vancouver to Canberra (1983-1991)

The overarching theme emerging from the Vancouver assembly was "justice, peace and the integrity of creation". Delegates were particularly conscious of the devastation of creation. The mandate of CMC was extended for another term under the Justice and Service unit. The completion of both the study process on health, healing and wholeness in industrialized regions of North America, Europe and North Asia, and the study on financing primary health care were priority tasks for the period following Vancouver.

The result of the study on Financing Primary Health Care was published in 1987 and entitled *Financing Primary Health Care Programmes: can they be self-sufficient?*

The conclusions of the study were as follows:

1. PHC programmes cannot be self-sufficient because their beneficiaries are so poor.
2. Community financing has to be one source in what should be a balanced financing approach.
3. Well-run programmes have a tendency to grow. Although they may be heading for a degree of self-reliance, they will still need additional funding if they are to do so.
4. Hospital-based programmes can become self-sufficient.
5. By entering into partnership, PHC and existing hospitals can increase each other's effectiveness.

The theological discourse on health and healing carried the generative theme of the Vancouver assembly, i.e., justice, peace, and the integrity of creation. It recognized the importance of being rooted in the Triune God and in right relationship with one another and creation. It recognized the powerhouse of a spirit-filled life, especially for life in community. The various faith resources available in church liturgies, such

as confession and absolution, the passing on of the peace, the Eucharist, and prayers for healing, are vehicles for genuine healing. The final concept of forgiveness is the restoration of the person to the community. It was emphasized in the Orthodox churches' input to the study in Egypt that sin shatters the community and forgiveness restores healthy relationships within community. Other church ministries that contribute to health and healing are visitation of the sick, care for the dying and suffering, and witnessing about the power of God's love and healing, even as one enters eternal life. Later in the nineties, people living with HIV/AIDS and differently-able persons demonstrated the realization that illnesses and physical defects could be turned from threat to opportunities for witnessing about the nature of health, healing and wholeness.

The injustice and inequities in health became even more glaring as nations experienced the burden of international debt and its implication in the allocations for debt servicing in the national budget in the eighties. Peoples' movement for change became stronger. More non-governmental organizations (NGO) were being created and represented in world bodies like WHO and UNICEF. Each was claiming the space for public discourse on health as opportunities for interventions were given to NGOs in international meetings. Some of these NGOs were supported with seed grants by CMC or endorsed by church-related funding agencies in the North. NGOs varied from those that were more political in nature to those that ensured health workers were trained to care for the health needs of the people.

The Pharmaceutical Programme, which had been established in 1981 and was led by the Pharmaceutical Advisory Grou (PAG), entered its second phase in 198 1991 with attention given to networking a the promotion of the essential drug co cept. Representatives of donor agenci dealing with pharmaceutical programme WHO and UNICEF continue to participate the PAG meetings.

Meanwhile, during this period, the AI epidemic was becoming an enormous pu lic health problem. Yet, the churches' r sponse suffered a long delay because moralistic discourse. CMC published *Wh is AIDS?* in 1988. The publication was di tributed free of charge and was translate into different languages all over the worl Consultations on pastoral care and pastor counselling were organized in Moshi and the Caribbean. *Learning About AIDS* a pastoral counselling manuals were subs quently published for the guidance of pa tors and counsellors.

The final results of the study on Healt Healing, and Wholeness were reported du ing the WCC central committee in Mosco in July 1989. Member churches were cha lenged to make policy statements on the involvement in health care and healing, thu re-affirming the healing ministry of the church. The central committee's challeng implied the de-professionalization of healt care and healing, and the building of th care-giving capacity of every member of th congregation. The report was finally pub lished as approved by the WCC Centra Committee.

The report introduces a new definition of health:

"Health is a dynamic state of wellbeing of the individual and the society; of physical, mental, spiritual, economic, political and social wellbeing; of being in harmony with each other, with the material environment and with God."[15]

This definition builds on the one that is well-known, developed by WHO, but adds some new elements, particularly the notion of spiritual, economic, and political wellbeing. According to CMC, health is seen as a dynamic condition and not as an entity that humans can possess or keep at any given time. A person is neither completely sick nor completely healthy but is always in a dynamic process of more or less health or disease respectively.

This new CMC definition differs from the WHO definition in that health is no longer essentially an individual affair but includes society. The CMC approach introduces the position of the individual in society and the spiritual dimension of health into the discussion.

15 WCC, Healing and Wholeness – The Churches' Role in Health., 1990, p. 6.

Interestingly, the WHO has subsequently subscribed to this aspect of health[16] and the WHO constitutional review board suggested its new definition of health should read: "Health is a dynamic state of complete physical, mental, social and spiritual wellbeing and not merely the absence of disease".[17]

The influence of the CMC definition on this revised WHO definition is obvious.

The report to the central committee in 1989 repeatedly mentioned the term wholeness, which has been frequently used in the ecumenical discussion but never precisely defined. The vagueness of this term is certainly a shortcoming not only of this report but also of many CMC documents. In general, wholeness means the unity of body, soul and spirit that is challenging the dominant philosophy in scientific medicine with its tendency to reduce everything to the physical aspects of the human organism.

The term wholeness is closely related to the term shalom as used in the Old Testament to refer to the harmony of the human being with himself, with his fellow human beings, with his environment and with God. Therefore, wholeness is an important term, but Protestant theologians raise concerns not to misuse this concept to contradict the biblical view of the human person. In the Bible, the human being is imperfect, sinful and finite in nature so that no person in this age and time can ever achieve wholeness. This term points to the kingdom of God and to the eschatological realization of God's in-

16 Antezana, Health for all in the 21st century, 1998

17 WHO, Review of the Constitution and regional arrangements of the World Health Organization, 1997

tention for humankind. Wholeness in the sense of shalom is a perfect condition that will only be realized when God's kingdom is finally established.[18]

These concerns about definition have to be taken seriously, because vague terminology permits any ideology to claim to be holistic, and any healing method that is not based on scientific medicine to call itself holistic healing. An alternative terminology expresses the very important concept of shalom in a better way. The theologian Dietmar Schicketanz,[19] who wrote his dissertation on the CMC study process, suggests the term "multidimensional healing" as preferable to the term "holistic healing".
Paul Tillich from a theological point of view and Viktor Frankl from a psychotherapeutic background independently developed the anthropological concept of the human being as having multiple dimensions. According to them, human beings have different dimensions such as physical, chemical, biological, mental, spiritual and social. All these dimensions influence each other. If applied to practice, consideration of these dimensions could benefit both medicine and pastoral care. Any kind of treatment will be more successful if it is specifically addressing the dimension responsible for the disease or illness. If a specific method of treatment addresses the wrong dimension or only one dimension without taking into consideration possible effects of this treatment on other dimensions, then the healing process as a whole may suffer adversely. Various disciplines tend to take their preferred dimension as absolute. Consequently, a discipline usually explains an treats a disease according to the dimensio in which that discipline has its expertise. Fo example, medicine prefers the biological di mension, faith healing the spiritual dimen sion and sociologists the social dimension.

Taking the multiple dimensions of human life seriously enables medicine to concentrate on the biological dimension without losing sight of the mental, social and spiritual dimensions, and vice versa for the other disciplines.

9 Recent Developments and the Futur

In its original form, the CMC no longe exists. The seventh assembly of the WCC i Canberra in 1991 decided to integrate th CMC into a new health team that would b part of a new unit II of the WCC. The new team was named "CMC – Churches' Actio for Health" and continued to deal with im portant questions of church-related healt care work.

The AIDS pandemic became all the mor a challenge for worldwide institutions in cluding the churches, with a devastating ef fect on the capacity of hospitals and th whole health care system. At the same tim there was a growing weakness in the na tional coordinating agencies and the hospi tals and health care programmes they serve The response for developing congregation based health care or healing communitie was slow. Traditional healing practices and so-called faith healing became commercial ized. Dr. Rainward Bastian, a commissioner of CMC since Vancouver, expressed his dis illusion and sadness at the turn of events There was a lot of hope in the seventies bu

18 Eibach, Heilung für den ganzen Menschen? 1991
19 Schicketanz, Vernachlässigte Dimensionen von Gesundheit und Krankheit, 1992

in the nineties it was apparent that there were many limitations in what the global and national programmes could achieve. Health for All by the Year 2000 remained a slogan without any reality. Bastian called for a new sense of realism.

Two studies on HIV/AIDS were conducted after the Canberra assembly. The first one had to do with participatory action research on AIDS, and the community as a source of healing. This was conducted in Uganda, Tanzania and Zaire and was reported in the 1994 central committee meeting in Johannesburg. This meeting called for a wider study on HIV/AIDS to help the ecumenical movement to shape its response in three areas: theology and ethics, pastoral care and the church as a healing community, justice and human rights. The study challenged the churches to be more honest, more faithful and better informed, and also to become safe places for people living with HIV/AIDS. It recognizes that everyone is vulnerable and in need of healing. In addition to the book *Facing AIDS* which contained a full report on the study including what the churches can do, an educational module on *Education in the Context of Vulnerability* was published and disseminated in regional networks.

The official study report on HIV/AIDS that the central committee adopted in 1996 dealt with all these issues. A statement was adopted and sent to all member churches with a recommendation for further reflection and implementation.[20]

A study to ascertain the viability and sustainability of church health care institutions and programmes was mandated by the new unit II Commission meeting in Evian, France, 1992. The aim of the study was to investigate how church health care institutions were faring, what coping and adaptation mechanisms they were adopting, and what was being done to ensure their sustainability. The study was designed and carried out in four stages from October 1994 to May 1997 with the help of a Study Advisory Group. The result of the study was published in 1998 under the title *Sustainability of Church Hospitals in Developing Countries: A Search for Criteria for Success.*[21] The following were the salient findings of sustainable church hospitals:

1. Christ-centred vision, do-able mission, and objectives that were revisited and revalidated at regular periods.
2. Active presence of a governing board from a variety of competencies, and adequate representations of stakeholders with visionary governance.
3. Committed managers and technical staff members who provide dynamic leadership.
4. Long-standing reputation for quality of care.
5. Assurance of quality, quantity and stability of staff.
6. Solid financing and financial administration.
7. Viable locations that make it possible for hospitals and health care institutions to earn reasonable and consistent incomes.
8. Commitment of the churches to the health ministry.

20 WCC, Facing AIDS, 1997

21 Asante, Sustainability of Church Hospitals in Developing Countries, 1998

9. Government policies that are conducive towards private providers of health care.

In the following years, the financial problems of the WCC required severe reductions in funds and personnel despite the important work the health team was doing.

It was in this period that the WCC looked for new ways of assisting churches in their ministry. Certain programmes were farmed out in the region. The Pharmaceutical Programme was also based in Africa but has continued to be accompanied by a Pharmaceutical Advisory Group that meets at the WCC on a regular basis. *Contact* continues to be a vehicle for communicating health and healing. The publication is now produced from India through the Christian Medical Association of India.

In anticipation of a new restructuring of the WCC, with health concerns being integrated in the work of a new Mission and Evangelism Team, an advisory group that met in February 1997 suggested specific priorities after the WCC eighth assembly in Harare, Zimbabwe. These were: faith and healing; the challenge of bioethics; morality and the market; enabling the churches to address the challenges posed by HIV/AIDS.

After the 1998 Harare assembly, the health team was reduced to the equivalent of 1.8 full-time staff, who are part of the mission and evangelism team within the new structure of the WCC. Therefore, the work cannot continue in the same way as before. Even though the health-related work within the WCC has changed considerably, it will nevertheless remain a central concern of the WCC and of the whole ecumenical movement. His Holiness Bishop Aram, t moderator of the central committee, clea expressed this continued concern in his a dress to the Harare assembly. Concerni the healing ministry of the church, he said

"Churches recognize that they are calle by God, through the example of thei Lord and by the power of the Holy Spirit to be healing communities and to be involved in the ministry of healing. In world that is marked by brokenness through war, injustice, poverty, exclusion and ill health, they are gifted with the possibility of finding healing, forgiveness and wholeness and to bring these gifts to bear in society. ... Through its programme *CMC – Churches' Action for Health*, the Council has carried out the specific mandate of equipping, strengthening and enabling the churches to participate fully in this ministry of healing. ... The churches are challenged to bring the full range of their resources to bear on human brokenness, as a sign of God's desired fullness of life for all. While it will not be possible to continue to conduct programmes in this area in the same style as in the past, the healing ministry of the church, as an essential dimension of the churches' missionary calling, should continue to be one of the foci of the Council's work."[22]

22 Aram I, p. 50-52.

10 Conclusion

This review of the ecumenical discussion of health, healing and wholeness demonstrates the importance of this discussion for the churches in general and the WCC in particular. It also shows how the concepts, terms and actions have undergone important changes over the years.

The conferences, studies and documents of the CMC have had important consequences. They have influenced the creation of the concept of Primary Health Care and the health systems of many countries as well as the understanding of health and disease. Industrialized countries where the health care systems are relatively well financed and firmly in the hands of representatives of scientifically based medicine are much more difficult to influence and to change. Nevertheless, the last decades have seen an increase in the attention paid to the discussion of health, healing and wholeness in the ecumenical movement. Church institutions over the centuries have done pioneering and innovative work in the field of health care. Many excellent initiatives were later integrated into national health care systems and lost their specifically Christian character without denying their origin. Some examples are hospices and care for the dying, diaconical work in the congregations, community based health care and the concept of Primary Health Care.

Christians have the duty, therefore, to constantly look for new answers to the burning questions that arise in every generation. Christians and church institutions are challenged in a particular way to contribute as much as they can to the wellbeing of all people. Currently, there is no lack of health care problems in any part of the world. In both industrialized countries and developing countries, Christians should continue to look for new ways and responses by building on the results and experiences of the ecumenical discussion of health and healing. At the same time Christians all over the world should continue to exchange ideas and views about health, healing and wholeness to stimulate and enrich their churches and communities in the constant search to be healing communities and in the desire to help people to have life in all its fullness.

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The Human Being is a Multidimensional Unity

The Christian Churches Have a Special Healing Ministry

As a sign of the coming of the Kingdom of God, Jesus healed many people from physical and psychological diseases. Jesus charges and empowers his disciples to preach the Kingdom of God and to heal. How can we interprete and fulfill Jesus' healing ministry today?

The anthropological model of the human´s multidimensional unity, developed by Paul Tillich and Viktor Frankl, leads to an extended understanding of healing. This makes it possible to understand the character of spiritual healing and to integrate it into the field of the contemporary therapeutic disciplines.

Beate Jakob

1 Introduction

Many disciplines currently claim to be involved in healing. Medicine deals with the elimination of physical symptoms, psychotherapy treats psychological disorders and sociology tries to restore troubled relationships. In these disciplines, diagnosis and therapy are based on scientific evidence. How does Jesus' healing ministry relate to these many therapeutic possibilities? Is Jesus' healing ministry "absorbed" by these scientific disciplines so that it looses its uniqueness, or is it placed beside or even above these disciplines?

In 1964, a consultation on the questio of the Christian healing ministry took plac at the German Institute for Medical Missio in Tübingen. It was organized following th initiative of the WCC Department for Worl Mission and Evangelism and the Luthera World Federation's Commission for Worl Mission with the purpose of clarifyin whether or not there is a difference be tween the Christian medical service and th activities of secular aid agencies.

A single sentence expresses the findings of this consultation: "The Christian churches have a special healing ministry."[1]

The present essay attempts to elucidat this sentence by first explaining Jesus' heal ing miracles. Then, this essay will identif the persons to whom Jesus entrusted hi healing ministry and explore how Jesus healing ministry has been interprete throughout the centuries. Finally and mos importantly, this essay will offer some sug gestions about how Christian churches ca understand and implement Jesus' healin ministry in the contemporary world.

1 ÖRK, Auftrag 37

2 Jesus' Healing Miracles

Understanding Jesus' healing miracles is essential to interpreting Jesus' healing ministry. Jesus' affirmations such as "The time is fulfilled, and the Kingdom of God is at hand" (Mark 1,15) and "The Kingdom of God is in the midst of you" (Luke 17,21) scandalized many of his contemporaries. With these words, Jesus made it clear to everyone that he was the one who will and has already begun to fulfill their hopes of the promised time of salvation.

Jesus' healing miracles must be interpreted within the framework of his message of the Kingdom of God. These miracles do not primarily present Jesus as a miraculous healer to be consulted in case of disease. Rather, they show that through Jesus, God devotes God's attention to this world completely and forever. Jesus himself interprets his healing miracles by saying, "But if it is by the finger of God that I cast out demons, then the Kingdom of God has come upon you" (Luke 11,20).

Jesus' healing miracles are real; sick persons are healed. Nevertheless, they are also "relative" in that they must be seen in relation to Jesus' entire Gospel. Jesus' activities show the connection between salvation and healing. Jesus' healing miracles are part of this salvation, and they reveal to those involved that Jesus wants them to make a decision.[2]

Jesus' healings are miracles in so far as they mark the starting point of a completely new reality that has never been experienced before.[3] They introduce the new creation that will divide the times into a "before" and an "after".

As signs of the eschatological in-breaking of the Kingdom of God, Jesus' miracles do not legitimate him as a healer or even as the son of God. They are not his identity card, but they are signs or signals of God's Kingdom. Jesus' healings do not primarily provide physical or psychological health to individuals but rather provide an invitation for people to come into contact with God.

Consequently, Jesus withdraws if people want to monopolize him as a miracle worker (see Mark 1,38)[4], and Jesus does not allow those whom he healed to go and promote him (see Mark 1,44). Jesus does not want the healing to be misunderstood and separated from the framework of his Gospel.

3 Jesus' Healing Ministry Entrusted to His Disciples

Jesus wants his disciples to participate in his mission. He asks them to continue his work and endows them with the authority they need.

The missionary instructions in each of the Synoptic Gospels connect the proclamation of the word with deeds and explicitly mention the healing ministry. For example, Matthew 10, 1.5.7 reports, "And he called to him his twelve disciples and gave them authority over unclean spirits, to cast them out, and to heal every disease and every in-

2 To Jesus healing miracels cf.: Arnold, Glaube 80; Flammer, Jesus; Häring, Glauben 37; Kruhöffer, Mensch 39; Röckle, Aufgabe

3 Cf. Beinert, Glaube 145f

4 Cf. Schnider, Überlegungen 64-67

firmity... These twelve Jesus sent out, charging them ... and preach as you go, saying, "The kingdom of heaven is at hand". Heal the sick, raise the dead, cleanse the lepers, cast out demons!"

Jesus entrusts the apostles with preaching the Kingdom of God and healing the sick. The Gospel According to Luke reports that on another occasion, Jesus also entrusted his ministry to 72 other disciples. In Jesus' instructions, the Gospel cannot stand without the concrete salvation illustrated by the healings, and the healings lose their meaning if they are not seen within the framework of the Gospel of God's Kingdom.[5]

In the Gospel According to John, Jesus does not explicitly entrust his disciples with his healing ministry. Nevertheless, he implicitly pronounces this ministry when he says, "Truly, truly, I say to you, he who believes in me will also do the works that I do; and greater works than these will he do, because I go to the Father" (John 14,12). The entire Gospel According to John demonstrates that Jesus' works include healing (see John 5,17-20; 9, 1-4; 7, 3.21; 10, 25. 31-38).

Jesus' disciples were entrusted with his healing ministry and received the necessary authority. Does this healing ministry only apply to those disciples who were directly addressed by Jesus?

Was this ministry limited to the times the Early Church, or should and could it observed even today? Does it apply to co temporary Christianity? These are importa questions to consider.

Two arguments substantiate an endu ing validity of Jesus' healing ministry

First, Jesus brought the time of salvatio into the present. In Jesus, God has inte vened into history once and for all. Th Kingdom of God has already begun at lea since Easter. In John's Gospel, Jesus repea edly promises his disciples to give them th Holy Spirit for the time when he himse leaves this world. He says, "And I will pra the Father, and he will give you anothe Counselor, to be with you forever" (John 1 16). The time of the Church is the time the Holy Spirit. "Jesus' departure does n lead into a time without salvation, but into permanent time of salvation".[6] One aspect this time of salvation is the concrete salva tion evidenced in the healing miracles.

Second, the Christian healing practic during the first centuries after Christ argue for the permanent truth of the healing min istry. The final chapter of Mark's Gospel tha was probably added in the 2nd century C.E describes the healing practice of the earl Christians.[7] For the Christian authors in th first centuries after Christ, healing was a essential part of the Churches' life. For ex ample, Origin and Augustine point out tha the mission ministry of the Church wa meaningless if within the congregations n concrete salvation was visible.[8] Ignatius Antioch writes in his letter to the Ephesians

5 To Jesus' healing ministry-see: Beare, Mission; Hengel, Nachfolge; Ittel, Jesus 49-59; Kremer, Kranke

6 Becker, Evangelium 555f
7 Cf. eg: Webel, Heilen 103f
8 Lohfink, Jesus 174-176; Pesch, Heilungsauftrag 8f

"There is only one doctor for body and soul ... Jesus Christ our Lord"[9]. For the early Christians, Jesus, the Savior, was the one who healed. Christ was addressed as "Physician", and the prayer "Help us, Christ, you alone are our physician"[10] was common.

4 The Historical Development

The affirmations and prayers of the early Christians may seem strange to many contemporary people who have difficulties with Jesus' healing ministry. Throughout the centuries, Christians have taken Jesus' ministry to proclaim the Gospel very seriously, but Jesus' healing ministry has had less importance.

A brief explanation for the neglect of Jesus' healing ministry is in order.

Advances in medicine partially explain the neglect of Jesus' healing ministry. Christianity emerged at a time when the common idea of the "priest-doctor" had almost lost its significance. Since Hippocrates in the 4th to 3rd centuries before Christ, medical research started to develop from the occidental understanding of science that ultimately led to an emancipation of medicine from religion, and Christianity did not reverse this trend. Medicine claimed and ultimately received the professional competence for physical care. In the 19th century, new scientific disciplines such as psychology and sociology developed with their claim and offer to heal people.[11] The medical doctors eventually received a universal claim to health matters. The disillusioned and resigned summary of this development is that "Jesus' miracles have fallen into the hands of medical doctors, psychologists and sociologists"[12] and Christianity no longer claims a place among the many therapeutic approaches. Theology has forgotten or abandoned the therapeutic dimension of the Christian tradition.

Another partial explanation for the neglect of Jesus' healing ministry is that contact with philosophical systems increasingly challenged Christianity to prove itself. In response, Christian theology developed affinities toward the humanities. As Christianity developed toward a teachable truth, Christian salvation was increasingly seen from the intellectual point of view and was interpreted as a doctrine and a teaching. The expectations of salvation were more and more limited to introspection and salvation of the soul. Healing became a subject of soteriology and was restricted to spiritual healing. Theology addressed the human being as a sinner at risk of loosing the eternal salvation of the soul. Consequently, the healing ministry became less and less important as the Christian tradition developed.

Under the influence of Greek philosophy, a Christian attitude increasingly negative toward the body and physical life developed. This development began in the New Testament and fostered a growing resignation of Christians toward suffering.[13] Hence, the accounts of healing miracles in the Gospels were increasingly interpreted spiritually as healing from spiritual blindness, paralysis and deafness.

9 Fizzoti, Dimension 129
10 Cf.: Biser, Theologie 102; Harnack, Medizinisches 132-147; Roth, Christus medicus
11 To this development cf.: Arnold, Glaube 37-46; Biser, Heilkraft 536-538; Biser, Theologie 93-102
12 Biser, Glaube 33
13 Arnold, Glaube 37f

In spite of the dominant tendency to restrict salvation to the spiritual arena, some continued interpreting Jesus' healing ministry as an instruction to care for the sick according to the example of the Good Samaritan (Luke 10) and the works of mercy in Matthew 25. Many hospitals for the care of the sick and elderly were built at Christian initiative. These institutions have been and remain very beneficial, but they did not directly emerge from the dominant spiritual interpretation of Jesus' healing ministry.[14]

In contrast to the tendency to neglect Jesus' healing ministry, the 1964 Tuebingen Consultation at the German Institute for Medical Mission emphasized that the Church has a special healing ministry. This emphasis on the special healing ministry of the church does not turn back history and resume the competition between Christianity and the medical sciences to regain ground for religious healing.[15] Instead, the Church gratefully accepts the successes and possibilities of these disciplines as a gift from God and makes use of them. At the same time, the Church does not withdraw from the therapeutic landscape but assumes its appropriate position of counteracting the mistaken assumption that the medical sciences are absolute.[16]

5 The Healing Ministry Today

What can Christians consider as their special responsibility in the field of healing?

14 McGilvray, Gesundheit 15-17
15 Cf. eg: Biser, Glaube 54
16 Biser, Theologie 114

The answer to this question requir clarification of the notion of healing.

Healing relates to human beings, ar every interpretation of healing is based on certain anthropology. The different healir disciplines often limit the conception of th human person by dividing a person into di ferent segments. In medicine, for exampl a human being is reduced to the body. I sociology, a person is seen as one compo nent of a social structure. By concentratin on the so-called salvation of the soul, theo ogy also often reduces the human person t a single dimension. Not only the various sc entific disciplines but also theology ha largely lost a clear focus on the human per son as a holistic and comprehensive being.

5.1 Healing According to Viktor Frankl's and Paul Tillich's Anthropology

Independently from each other, Vikto Frankl, who founded Logotherapy in Vi enna, and Paul Tillich, a German theologia who emigrated to the U.S., developed an thropological models that counteract th segmentation of the human person.

Considering the plurality and specializa tion of the sciences, Frankl and Tillic wanted to make the public aware of th dangers of a reduction or segmentation o the human person. They reacted to the an thropological models of Max Scheler and Nicolai Hartmann, who differentiate among the various layers or levels withi each human being. These levels include the physical, psychological and spiritual as pects of the human person.

Frankl and Tillich introduced the essen tial notion of "dimension" into anthropol

ogy. Talking about levels within a human being encourages thinking of the different aspects of being as independent from one another. Levels are like layers that are juxtaposed to each other but not connected. The notion of "dimension" is different. Describing the human body, soul and spirit as dimensions means that these aspects of being permeate one another just as the three dimensions of space. The dimensions of being are not separated from each other, but each one is part of the other and permeates the other.

Frankl formulates this integrated conception of the human person by saying, "Man is a unity in spite of his diversity".[17] Similarly, Tillich says that the human person is "a multidimensional unity."[18]

Even though all dimensions of life are integrated within a human being, the spiritual dimension is a specifically human dimension and is the most comprehensive dimension. The phenomena of conscience, love and religion are localized in this dimension.[19] Only the human person can reach this spiritual dimension, but the person at the same time is still body. The physical dimension is thus present within the spiritual dimension and vice versa.[20]

Unfortunately, the different sciences that treat human beings reduce the multidimensional unity of the human person to one level by emphasizing one aspect from the spectrum of reality. Medicine reduces this multidimensional unity to the physical level and psychotherapy to the psychological level. According to Frankl, this reduction of focus is not only legitimate but also obligatory. However, Frankl encourages the awareness that this one-dimensional view of the human is only an abstraction and that a medical doctor should realize that a physical disease always affects a human as a holistic being in all dimensions of life.[21]

The anthropological model of the multidimensional unity of the human person has consequences on the understanding of healing. Tillich illustrates these consequences when he writes, "The multidimensional unity of man calls for a multidimensional concept of health, of disease, and of healing, but in such a way that it becomes obvious that in each dimension all the others are present," and also: "Health and disease are states of the whole person…Healing must be directed to the whole person."[22]

The statement that all other dimensions of life are integrated into each single dimension implies that physical, psychological and spiritual healing are related to one another. Consequently, the healing disciplines should cooperate to address all the aspects of the human person. Tillich states, "The correlate of the multidimensional unity of life is the multidimensional unity of healing".[23] Just as there are different dimensions of a person, so also are there different methods of healing. Tillich continues, "There are special helpers and healing methods called for un-

17 Frankl, Pluralismus 143
18 Tillich, GW IX 289
19 Cf. : Gespräch, 21f; Kreitmeir, Seelsorge 246f
20 To this model: Böschemeyer, Sinnfrage 52-59; Frankl, Pluralismus 142-148; Frankl, Seelsorge 46-51; Kreitmeir, Seelsorge, 113-120. 128-133
21 Frankl, Pluralismus 147; cf. also Nüchtern, Kritik 488-491
22 Tillich, Meaning 347; Tillich, Systematic Theology III 277
23 Tillich, Systematic Theology III 281

der every dimension".[24] These special methods of healing, however, should not compete with one another, but they should enter into dialogue and cooperate. Tillich concludes, "If man must be considered as a dynamic unity of diverse elements ... religion, psychiatry, and medicine are united, though not identified..."[25]

Tillich indeed places religion within the therapeutic landscape. He calls the specifically religious method of healing "spiritual healing". What exactly is his conception of "spiritual healing" and how does this healing relate to the other methods of healing? Tillich defines "spiritual healing" by explaining, "In the spiritual field healing means, that the human spirit is touched by something, that transcends it and leads it to it´s genuine being."[26] Spiritual healing is primarily intended to heal the human/divine relationship by the healing power of the Holy Spirit. Concerning the relation between spiritual healing and other healing disciplines, Tillich states: "The healing impact of the Spiritual Presence does not replace the ways of healing under the different dimensions of life. And, conversely, these ways of healing cannot replace the healing impact of the Spiritual Presence."[27]

Tillich establishes two principles. First, he notes that every disease or infirmity requires specific treatment within its dimension. A broken leg should be treated surgically, and internal inflammations need internal treatment. It is inappropriate to treat these infirmities primarily by spiritual healing. Nevertheless, every disease affects t human being as a whole, and it therefo also affects the spiritual dimension. A the apy of the spiritual dimension can impro the response of a physical symptom to me ical treatment. So spiritual treatment can i deed have a positive impact on the physic well being of a sick person.

Second, Tillich notes: "these ways healing cannot replace the healing impa of the Spiritual Presence." These othe methods cannot perform what is specifica spiritual. They cannot heal the human rel tionship with God. Tillich points out th this limitation especially pertains to psych analysis.[28] During Tillich's life, psychoanal sis was increasingly becoming a kind secularized pastoral care. Tillich correct notes that it will always be the responsibili of spiritual healing to address the huma alienation from God, whereas psychologic problems may be healed by psychotherapy.

Tillich warns that spiritual healin should not be neglected in preference t the popular psychotherapeutic methods healing. Addressing a group of theologic students who were about to assume thei parish ministry, he delivers a speech enti tled "Heal the Sick ... Cast Out Demons and states: "You are not supposed to b physicians; you are not supposed to be psy chotherapists; you are not supposed to be come political reformers. But you are sup posed to pronounce and to represent th healing and demon-conquering power im plied in the message of the Christ, the mes sage of the forgiveness and of a new reality You must be conscious of the other ways

24 Tillich, Meaning 351
25 Tillich, Relation 231
26 Cf. Elsässer, Paul Tillich 23
27 Tillich, Systematic Theology III 280

28 Tillich, Syst. Theology III 322

healing. Yor must cooperate with them, but you must not substitute them for what you represent."[29]

Tillich holds that it is essential for the pastoral counselor not to abandon his or her identity through cooperation with the other healing disciplines but that this co-operation should generate new ideas and approaches of how to proclaim the healing power of the Gospel more effectively through counseling.

5.2 Consequences for the Christian Healing Ministry

Tillich's anthropological model of the multidimensional unity of the human person and his statements on healing are very useful in integrating Jesus' healing ministry into the contemporary world. First of all, the idea of a multidimensional unity of healing not only prevents pitting the various healing approaches against one another but also prevents substituting spiritual healing for any of the other approaches.

Second, Tillich's model integrates spiritual healing into the framework of the healing disciplines. Spiritual healing aims to heal the human alienation from God. It brings persons into the presence of the saving and healing power of the Holy Spirit. When a person is healed in the spiritual dimension, all other dimensions of his or her life are affected. He or she becomes a new creation. When humans encounter the healing power of God, extraordinary things may happen. Physical symptoms may disappear; psychological problems may be resolved; and social relations may change. In the spiritual dimension, salvation and healing are identical. The salvation experienced will very concretely affect every dimension of the human person.

Christianity possesses a therapeutic dimension, a healing power. When this power is permitted to develop, humans are changed and healed spiritually. In addition to this spiritual dimension, this salvation may also affect the physical and psychological dimensions. Some people may even be healed spiritually in spite of or even because of continued physical or psychological infirmities. These continued infirmities do not diminish Jesus' healing ministry and the therapeutic possibilities of the Christian faith. Jesus' healings did not primarily aim at giving health in the physical or psychological dimensions. He wanted to proclaim God's Kingdom and to heal the human/divine relationship, and this relationship is more important than anything else. Trusting in Jesus and in God's healing disposition, Christians may bring before God all their pain and sorrow as well as other people's suffering and may ask Him to heal their suffering in every dimension of life. Christians absolutely trust that God will give salvation. Just how this healing will happen must always be left to God. Christians should add to their prayer, "Thy kingdom come, thy will be done". The Christian church does have a special responsibility in the field of healing. It is absolutely essential for the church and for Christians to be aware of this responsibility.

Today, it is not humans in their awareness of being sinful but rather humans in their entire unholy existence with their intense longing for salvation that are the most responsive to the Gospel.[30]

29 Tillich, Eternal Now 63f

This reality applies to Western cultures but even more to other cultures. In Africa, Christian groups that concentrate on prayers for healing are much more attractive than the traditional churches. The same is true for Latin America, where people in distress are strongly attracted to a religion that is concretely linked with their lives. In Brazil, for example, the Pentecostal Churches attract large numbers of followers. One lecturer stated, "The poor have made an option for the Pentecostals!'

6 Applications

In conclusion, three suggestions about how Jesus' healing ministry could be fulfilled in the contemporary world are in order.

First, it is important not to lose sight of the sick at the congregational level. Practical options for avoiding this oversight include organized home visits and prayers for the sick during church services. In clinical pastoral care, a cooperation of the healing disciplines according to Tillich's anthropological model is important. As is already common in many hospitals, a participation of pastoral counselors at team meetings is an important step toward the multidimensional unity of healing.

Second, modern pastoral care is often too focused on reason and words. Pastors must think about the possibilities of how to approach human persons in their various dimensions. Liturgical options that achieve this end include blessing and anointing during hospital visits and services or laying on of hands as a special form of healing care.

30 Cf. Biser, Glaube 40

Through these acts, healing love and ca
become actualized and perceptible. Oth
liturgical forms such as the so-calle
Thomas Mass and the various liturgies f
the troubled and oppressed also embo
the therapeutic dimension of the Christi
faith.[31]

Third and finally, Jesus' healing minist
may be fulfilled in the care of chronical
and terminally ill patients if a dimension
life is discovered for these patients that
independent from physical health.[32] In thes
cases, healing means to give hope an
meaning in spite of suffering and to impa
the experience of God's love and solidari
in the midst of suffering.

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31 Cf.: Hollenweger, Verhängnis 155-164
32 Eibach, Heilung 146

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Healing – More than Seeing a Doctor

When one sees a doctor, one hopes for physical and psychological healing. Considering Jesus´ healings, we notice, that Jesus´ healings comprise "more". They aim at more than the physical or psychological recovery of the person. According to this today´s understanding of healing, health and illness can either comprise only the physical or psycholocical dimension of the human being or it can – in the sense of an extended, anthropological conception – consider all dimensions of the human being. The vision of a "healing community" focusses on this extended conception.

Beate Jakob

1 Introduction

The DIFÄM study department is currently investigating the topics of health, illness, and healing. This investigation explores the contemporary significance of Jesus' healing ministry and focuses on the question of whether or not Christians and the Christian churches have a special healing ministry.

The present essay entitled "Healing – More than Seeing a Doctor" furthers this investigation by considering healing and illness as more than physical. This essay promotes recent anthropological trends of extended conceptions of health and illness that transcend the narrow scientific or medical conceptions limited to the physical. This essay also demonstrates how Jesus' healing miracles both anticipate aspects of these trends and contribute to a Christi understanding of health as more than phy cal. Finally, this essay offers some refle tions on the church as a healing commun oriented toward an extended conception healing.

2 Scientific or Medical Conceptions of Health, Illness, and Healing

2.1 Physical Health

Medical science usually conceives health negatively as the absence of physical psychological disorders. Health is the smoo functioning of the system "human being."[1] this conception, health is vitality, efficienc and fitness for performing various tasks.

This understanding of health ignores in portant dimensions of life and presuppos a mechanistic image of the human being, reduced doctrine of life, and a reduced a thropology.[2] Sigmund Freud articulates th conception of health by saying, "Health the ability to work and to feel pleasure."[3]

This image of health corresponds wi contemporary ideals in society and is wid spread in various forms of media that po tray the happy and healthy person as t young, physically fit, sportive and vivaciou individual who can enjoy life to the full.

1 Nager, Gesundheit 5
2 Cf. Baumgartner, Seelsorge; Häring, Dienst 134; Nager, Gesundheit 5f; Stricker, Krankheit 65-71
3 See: Moltmann, Diakonie 81

2.2 Physical Illness

As the antithesis of health as the smooth functioning of the system "human being", medical science conceives of illness as a malfunction of this system, a deviation from the normal state of the body or a disharmony of the soul. Disease functions only negatively according to this conception and is limited to the physical dimension. This understanding of illness views sickness as a distortion of the ideal human being and a threat to human happiness and the enjoyment of a full and complete life.

2.3 Physical Healing

Considering health and illness as only physical, modern scientific medicine aims at objective results by defining malfunctions and, if possible, repairing them.[4] This repair happens in one of two ways. Either the body will regain balance in its physical and psychological functions by its own strength or by medical treatments that attempt to restore the body's physical condition before the disease occurred.

Healing in this sense is one-dimensional; it is aimed at the tangible symptoms of specific diseases and not at the sick person. Of course, this approach to healing usually meets the expectations of patients who desire relief from the symptoms and recovery from the disease as quickly and completely as possible. Nevertheless, the medical scientific focus on the physical aspect of health, illness and healing ignores other aspects that are crucial for understanding the well-being of humans.

4 Krumenacker, Gesundheit 84-91

3 Anthropological Conceptions of Health, Illness and Healing

3.1 Extended Health

In contrast to the scientific or medical conception of health that concentrates on the physical, the anthropological conception considers the whole of human nature. This conception assumes human nature is not limited to the purely vital but comprises various interconnected dimensions that must not be isolated from one another. A human being comprises physical and psychological dimensions as well as social and religious-spiritual dimensions.[5]

Health thus pertains not only to the physical and psychological dimensions but also to the social and religious-spiritual as well. Health is a harmonious flow of life in the various dimensions of human nature. Considering these dimensions, health is the harmonious relationship of a human with himself, the world and God.[6]

According to the anthropological conception, a healthy human being needs much more than physical functioning. Indeed, those who adopt this conception contend that a defect in physical functioning does not necessarily impede health.

J. Moltmann states: "Health is not the absence of illness or disability, but it is the strength to live with them."[7]

5 Cf.: Beinert, Glaube 69; Sporken, Sorge 38; Stricker, Krankheit 65-71
6 Eibach, art. Gesundheit und Krankheit 760
7 Moltmann, Diakonie 90

Chr. Grundmann concurs by saying, "Health is the ability to cope with the different challenges of life in a way that promotes life."[8]

Even though life's challenges may be physical defects or diseases, an individual can still live harmoniously with self, the world and God. The anthropological conception maintains that an individual can be a true and holistic human being in spite of or even because of physical disability.[9]

The dissonance between the scientific or medical conception of health and the anthropological arises from the insistence of the latter that health is the realization of one's true humanity and the fulfillment of the meaning of human existence.

U. Eibach asserts, "Health is the power to fulfill the meaning of life given to man."[10] Similarly, E. Schockenhoff states, "Man as a person is healthy if he is ready to meet his purpose in life and does not avoid difficult and adverse experiences."[11]

These authors conceive of health as the fulfillment of the meaning of human life and describe health as comprising everything that makes a human life succeed in substance and meaning.[12]

K. Barth succinctly expresses this anthropological conception by stating, "Health is the power to be a human being".[13]

The anthropological conception health may appear to place little value physical health, but does not intentiona deprecate the value of a healthy body soul. It simply reacts to an over-empha on the physical in medical science and e phasizes that health of body and soul is n everything but that other dimensions of t human being must be considered. Accor ing to the anthropological conceptio health is a challenge for individuals to pu sue a path toward true and holistic huma nature.

3.2 Extended Illness

Corresponding to the extended unde standing of health, the anthropological co ception of illness also relates to the who of the person. Diseases affect all dime sions of human life and are disorders in th harmonious flow of relationships that dete mine the life of each individual.

According to this extended understan ing, few if any human beings are entire healthy. All harbor healthy and sick compo nents in every phase of life. Health and di ease are in a dynamic balance.[14] Disease however, have not only negative but als positive functions. Disease as an "interru tion of a harmonious and unproblemat existence"[15] can cause the affected perso to reflect on the meaning of life. The exper ence of being sick and of dealing with di ease becomes an essential part of huma life. "Being sick is a way of being human".

8 Grundmann, Gesundheit 15f
9 Cf. Stricker, Krankheit 69
10 Eibach, Heilung 28
11 Schockenhoff, Ethik 221
12 Stricker, Krankheit 72
13 See: Eibach, Heilung 28
14 Stricker, Krankheit 72
15 Schockenhoff, Ethik 220
16 Häring, Dienst 137

3.3 Extended Healing

Considering health and illness in the context of the total person, the anthropological conception proposes a multi-dimensional understanding of healing. According to this conception, healing occurs in dimensions of the human person other than just the physical. A person is healed if she or he is cured not only from some physical or psychological disorder but also from any social or religious-spiritual disorder. Indeed, an incurable physical or psychological disorder does not preclude healing if a person succeeds in "being sick in a healthy way" by accepting and integrating the disease into her or his life. Healing occurs when a person does not lose the meaning of life in spite of suffering and disease.

The anthropological conception of healing is important in the care of the elderly, the chronically ill and the physically or psychologically challenged. Especially for the elderly, healing as the acceptance of impairments can lead to reconciliation with the finitude of life. This understanding of healing does not deny that diseases and disabilities are terrible but affirms that healing in large measure is the ability to establish and sustain sound and satisfying relationships with oneself, the world and God even in the most unbearable physical and psychological situations.

4 Christian Conceptions of Health and Healing

4.1 Jesus' Healing Miracles

The Christian understanding of health, illness and healing is more compatible with the anthropological extended conceptions that transcend the narrow scientific or medical conceptions limited to the physical. In fact, Jesus' healing miracles not only form the foundation for the Christian understanding but also anticipate certain aspects of the anthropological extended conceptions as well.

The Gospel writers report almost all that is known about Jesus' healing ministry.[17] In their report, they do not define health, illness or healing in abstract terms. Instead, they contextualize Jesus' acts of healing to communicate the meaning of Jesus' healing miracles.[18]

4.1.1 The Context of the Good News of God's Kingdom

The First Testament's teaching about the Kingdom of God provides an important context for understanding Jesus' healing ministry. Jesus tells his contemporaries that his appearance signals the appearance of God's Kingdom, which they had so eagerly anticipated. With him, the Last Days as the Time of Salvation promised and described by the prophets begin.

The Hebrew term *shalom* aptly characterizes these Days and this Time. This term means peace, healing, and the salvation of each individual and the world in a comprehensive sense. It implies not only the physical well-being of humans but also the complete and total well-being of all of God's creation.

From the First Testament's teaching, Jesus' contemporaries had very concrete expectations about the Kingdom of God in

17 Cf.: Pesch, Heilungsauftrag 4
18 Nüchtern, Krankheit 211

these Last Days. The Time of Salvation in these Days meant a state of complete peace and healed illness.[19] For these people, Jesus' message of the in-breaking Kingdom of God required concrete, tangible signs illustrated by visible activities. Jesus' healing miracles provide these signs. When the sick regain their health as a result of Jesus' ministry, people remembered the words of the prophet Isaiah, who wrote, "Then the eyes of the blind shall be opened, and the ears of the deaf unstopped; then shall the lame man leap like a hart, and the tongue of the dumb sing for joy" (Isaiah 35,5f.).

When Jesus' contemporaries fail to perceive his miracles as concrete signs of the in-breaking Kingdom and attempt to use him only as a miracle worker, Jesus retires and moves to other towns to preach the gospel of the Kingdom (Mark 1,34-38). Jesus' healing miracles are signs or symbols of the in-breaking Kingdom of God.[20] More than simply healing individual persons from their physical or psychological distress, they point to the Time of Salvation in the Last Days and open the eyes of Jesus' contemporaries to Jesus' role in the history of salvation.

4.1.2 The "More" in Jesus' Healing Miracles

Jesus' healing miracles address more than the physical and psychological dimensions of human existence. They treat the social and religious-spiritual dimensions as well. This latter dimension is particularly essential. Some of Jesus' miracles demonstrate that faith and physical healing are intricately connected. In these miracles, the healing of a human's relationship with God and the disappearance of a physical or psychological symptom occur simultaneously

In Luke 17, for example, Jesus heals t lepers and sends them to the priests. One the ten returns to Jesus to give praise to Go Jesus says to him, "Your faith has made y well". Jesus' comment to this one does n mean that the other nine contracted lepro again. Instead, it affirms that only this one completely healed. Only he discovers mo than just the absence of physical symptom Only he understands the real meaning of J sus' miracles (Luke 17,11-19).

Jesus' healing of the paralytic provid another example. After seeing the faith this person and his friends who broug him, Jesus says, "My son, your sins are fo given". A little later, Jesus performs th physical healing by commanding, "Ris take up your pallet and walk" (Mark 2, 12). This miracle clearly demonstrates th connection between the disappearance this man's physical symptom and the hea ing of his relationship with God.

Jesus' healing of a woman suffering fo twelve years from a flow of blood provides final conclusive example of the connectio between the physical and the religious-spi itual dimensions in Jesus healing ministr After exhausting her medical options, th woman approaches Jesus from behind an touches his garment. In this moment he bleeding stops. She is physically healed an her medical history has a "happy ending" For Jesus, however, the "event" has only be gun. Jesus turns to the woman and initiate a conversation in which the woman tel "the whole truth". Only then does Jesus sa to her, "Daughter, your faith has made yo well; go in peace, and be healed of you

19 Cf. eg: Betz, Wesen 22
20 Pesch, Heilungsauftrag 4f

disease". Her complete healing follows the removal of her physical symptom. Decisive for her healing is her personal encounter with Jesus. Her healing reveals that Jesus' healings are a personal event based on a close relationship with the person concerned and demonstrates the close connection of the physical and religious-spiritual dimensions in Jesus' healing ministry.[21]

Jesus cures physical illnesses. Nevertheless, he expressly states that physical wholeness is not everything but only a relative good. In a series of drastic statements, Jesus commands, "And if your foot causes you to sin, cut it off; it is better for you to enter life lame than with two feet to be thrown into hell. And if your eye causes you to sin, pluck it out; it is better for you to enter the Kingdom of God with one eye than with two eyes to be thrown into hell" (Mark 9, 45.47). Jesus is far from making physical health into an absolute but emphasizes the spiritual-religious dimension in his healing miracles.

In addition to the connection of the physical and the spiritual-religious dimensions, Jesus miracles also address the social dimension of human existence. Jesus often treats diseases that hinder the patient's relations with the community and result in social isolation. For example, the blind and deaf usually loose their means of income and become beggars. Leprosy patients suffer from their skin disease but more from their exclusion from the community. When Jesus touches leprosy patients and becomes "unclean" himself, he tears down social barriers and integrates these social outcasts into society once again (Mark 1,41). This integration of outcasts is an essential aspect of Jesus' mission. He wants to rebuild and restore the people of God. Beyond the healing of individuals, Jesus intends to heal the whole people of Israel.[22] This social dimension of Jesus' miracles often leads to a reaction from the crowds such as "God has visited His people" (Luke 7,16).[23]

Jesus' healing miracles concretely inaugurate the coming of the Kingdom of God and the Time of Salvation. The salvation offered by God through Jesus Christ includes more than the healing of physical or psychological disorders. They also address the social and the religious-spiritual dimensions as well. Jesus' healing miracles are not "one-dimensional" but address the physical, psychological, social, and spiritual-religious dimensions of life. When Jesus heals persons, he not only eliminates the physical symptoms but restores all dimensions of human existence in the realization of God's salvation. This "more" in Jesus' healing miracles shapes contemporary Christian conceptions of health and healing.

4.2 Contemporary Christian Conceptions of Health and Healing

For Christians, the essential aspect of human existence is the relationship with God. A person is only healthy if her or his relationship with God is intact.[24] Christian ethics categorically denies the absoluteness of

21 Baumgarten, Seelsorge 45

22 Lohfink, Jesus 22-24

23 Cf. Häring, Glauben 28

24 Cf.: Eibach, art. Gesundheit und Krankheit 760; Sticker, Krankheit 71

physical health. A healthy body is a great good, but health and wholeness are also present in illness and death when one's relationship with God is healthy.[25] A healthy person must always be understood in the context of a "healed" person. According to Christian teaching, health is nothing humans deserve or acquire. It is a gift or blessing bestowed by God, who gives health, not for its own sake but as an instrument humans use to contribute to the fulfillment of the Kingdom of God.[26]

In a Christian sense, healing means to experience the saving power of God.[27] God's salvation enables an individual to accept herself or himself as a person accepted by God. Regardless of life's circumstances, physical health or illness, strength or weakness, every individual can hear and respond to God's promise, "You are my beloved son or daughter, with you I am well pleased" (Mark 1,11). According to a Christian understanding, healing is affirmation of the self and progress in becoming the person God wants each to be.[28]

The Christian conception of healing does not negate the value of physical health or encourage suffering for its own sake. Instead, it points to the "more than physical" in health and healing. It integrates Jesus' suffering and passion into the understanding of wholeness and well-being. Jesus experienced extreme physical suffering, and yet his cross is the path to salvation. Eve human can be sure of Jesus' closeness a solidarity in suffering. Even though Jes suffered and died, he becomes by Goo power the paradigm of the healthy indivi ual who is complete and whole in the phys cal, psychological, social, and spiritual-re gious dimensions of human existence.

5 Conclusion: The Church as Healing Community

Following the "more" in Jesus' healin miracles, the church orients itself towar extended conceptions of health, illness, an healing. It defines itself as a community people who are all in need of healing o their way to the realization of the true hu manity in the Kingdom of God. It is a sharin community with everyone contributing ac cording to everyone's abilities. It is a plac where everyone finds compassion and mu tual acceptance.[29] The church is a healin community that encourages everyone to be come a whole and complete human being.

This notion of the church as a healin community sometimes provokes uneasines or protests of arrogance and utopian ideal ism.[30] This uneasiness or criticism may b justified if a healing community is under stood as a community in which some stron and healthy members want to relieve sic and weak persons from certain symptoms However, the church as a healing commu nity should not be understood in this wa Instead, all members realize that they ar sick apart from the grace of God. By experi encing God's healing grace, each membe becomes a channel for God's grace to ex

25 Cf.: Pesch, Heilungsauftrag 13
26 Cf.: Stoeckle, Gesundheit
27 Baumgarten, Seelsorge 123
28 Ibid.
29 Moltmann, Diakonie 91
30 Eg. Bach, Gemeinde

tend to others in need. In this community of mutual encouragement and edification, many members experience an improvement of physical and psychological symptoms. Just as important, however, each member realizes love and acceptance by fellow human beings and by God. The church as a healing community becomes a place where a person can find wholeness in every dimension of human existence, and such a community should provoke neither uneasiness nor protest.

As a healing community, the church is not in competition with modern scientific medicine. Instead, it advocates and promotes the advantages of medical science. The church, however, recognizes that medical treatments alone cannot produce a healthy person and accepts its unique role in the process of healing. As a healing community, the church possesses enormous potential to contribute to a healthy individual by providing a place where the social and spiritual-religious dimensions of human existence as well as the physical and psychological dimensions are addressed. Informed by the healing ministry of Jesus and by extended conceptions of health, illness and healing, the church indeed has a special healing ministry and advocates that healing is more than simply seeing a doctor.

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Does Faith Contribute to Healing?

Scientific Evidence for a Correlation between Spirituality and Health

Christoph Benn

Is there a correlation between practiced faith and health? Usually there is a strict separation between these two terms. They are referred to very different academic faculties: theology and medicine. At most faith and healing will be related to charismatic movements and faith healers whose practices cannot be verified by scientific methods.

However, recently there has been an increasing number of studies published in respected scientific journals using the tools of epidemiology to investigate the correlation between religion and health. Epidemiology is a science looking at the various factors that make people sick or help them to remain healthy. A number of scientists have now included factors such as membership in religious communities, faith or religious practices in their calculation. Interestingly enough many of these studies could show a positive impact on common problems such as coronary heart disease, malignant tumors or psychiatric illnesses. Most of these studies have been conducted in the United States of America. Some of them will be introduced in this article and analyzed according to their relevance and validity. It would be desirable that similar studies were conducted in Europe as well and that the results were recognized by theologians and physicians alike to promote a fruitful dialogue between these schools of thought. There is a great potential for a multidimensional approach to health that needs to be rediscovered and applied. The insights presented in this article can contribute to the required interdisciplinary cooperation.

1 Religion and Medicine

In the vast majority of human cultures, a close correlation exists between healing and religion. The priest-physician who fulfills religious and medical functions is common in many cultures. Such cultures conceive of healing as a process not easily understood or manipulated by ordinary human beings, but rather related to the transcendent and the holy. This concept changed dramatically in Western culture after the philosopher Descartes proclaimed the separation of body and soul. Now scientists were able to study the different parts of the human organism and to advance the study of clinical and preventative medicine. Since the Enlightenment, Western culture recognizes a division of labor between religion and scientific medicine. Religion and faith are responsible for the spiritual world that cannot easily be measured empirically, whereas medicine and the sciences are responsible for the material world including the human body. Without doubt, this innovation has greatly benefited humankind. Nevertheless, many people wonder whether

or not something has been lost in this development and whether or not attempts should be made to reconcile the various dimensions of the human person.

Since the beginning of the 20th century, this division of labor has undergone some changes. In psychology, practitioners of psychoanalysis and later psychosomatics began to question a mechanistic view of the human organism and rediscover the influence of the soul on the body. Researchers in the field of medicine called epidemiology examine the causes and effects of several factors on the health of populations and groups of persons. Apart from many other factors such as the environment, human behavior or social situations, these researchers are increasingly interested in factors related to religious practice and the affiliation with religious communities. Their studies show a close correlation between religious practice and health and help both religion and medicine to find mutual understanding and a common language. In response to these changes in the division of labor between theology and medicine, Kenneth Vaux remarks:

> "Although it is still unfashionable to ask questions about the religion/health interaction, it is evident that the long century of dissociation between religion and health sciences is coming to a close"[1].

There are two different models of and justifications for the healing ministry of the church. One model promotes caring for the sick because of charity.

1 Vaux, Religion and Health, 1976, p.522

During the 20th century, scientific medicin has become increasingly interested in th spiritual dimension of the human perso and theology in the physical aspects of pe sons as the foundation of several new inst tutes demonstrates. The National Institut for Health Care Research was founded in th USA to study more closely the relationshi between faith and healing and to collect an publish various scientific approaches to th topic[2]. The Mind/Body Institute at the Ha vard Medical School introduces spiritual e ements into medical training. Dr. Herbe Benson, the director of this Institute, ha published many articles and books[3] tha have been recognized also in German (Benson 1997). On October 8, 1998, th weekly newspaper *Die Zeit* published an ar ticle entitled *God is Healing – Believer Live Longer*. This article reports not only o the work of Dr. Benson at the Mind/Body In stitute but also on the efforts of the Nationa Institute of Health Care Research.

In addition to the founding of new insti tutes, numerous scientific publications als demonstrate the growing interest in th connection between religion and health Levin and Schiller reviewed more than 20 epidemiological studies examining the in fluence of membership in a religious com munity and of practiced faith on differen diseases as well as on life expectancy[5]. The conclude that there is a clear correlatio

2 Larson, Swyers, McCullough, Scientific Research on Spiri tuality and Health, 1998 Matthews, Larson, Barry, The Faith Factor, 1993

3 Benson, Timeless Healing 1996

4 McKee und Chappel, Spirituality and Medical Practice, 1992

5 Levin, Schiller, Is there a Religious Factor in Health? 198 Levin, Vanderpool, Is Frequent Religious Attendance Really Conductive to Better Health? 1987

between religion and health and that religious practice has a therapeutic effect on health in general. Even though a correlation is not yet evidence, Levin states after considering all the factors that influence health and disease, "Is there a positive correlation between religious practice and health? The answer is clearly 'yes'. Is this correlation valid? Probably. Is it unequivocally causal? Perhaps"[6]. Levin and other authors of scientific publications demonstrate the increased interest in the role religion plays in health and especially in disease prevention and cure.

2 The Results of These Studies

These studies show that faith and religious practice is effective in preventing and treating specific diseases such as heart disease, malignant tumors, and psychiatric disorders. These studies also indicate that religion extends life expectancy in general and that specific religious attitudes and practices are especially effective.

2.1 Specific Diseases and Life Expectancy

2.1.1 Diseases of the Heart and Circulatory System

George Comstock, a well-known American epidemiologist, conducted one of the classic studies on the relationship between health and religion[7]. He examined the correlation between the frequency of church attendance and the mortality rate for coronary heart disease. The surprising result was that men who attended their church at least once a week had a mortality rate for coronary heart disease that was 40 percent less than men who did not attend any religious services. He discovered an even more pronounced correlation among women. Those who rarely attended church were twice as likely to die from coronary heart disease than those who attended church regularly.

Correctly interpreting the results of Comstock's study requires consideration of whether or not church attendance might only be a confounding factor to other conditions actually responsible for the improved health. For example, those who attend church usually belong to the middle class or smoke less or live in a wealthy environment. Dr. Comstock's study made adjustments for all these sociological variables and found that the correlation between church attendance and reduced heart disease was valid even if all the other variables were considered. Of course, the correlation need not be causal since other factors directly related to church attendance such as the release of tension, reduced stress, finding meaning in life or belonging to supportive groups may actually contribute to the improved health status. Comstock's study used a very large sample size of more than 91,000 persons over a period of several years. This huge sample size is necessary to study a relatively rare event like mortality from a certain disease. The results of his study are statistically highly significant and certainly not due to an insufficient sample size.

Another study examined 232 patients who were to undergo open-heart surgery for a coronary bypass or replacement of aortic valves[8]. Statistics indicated that about 10

6 Levin, Religion and Health: Is there an Association, is it Valid, and is it Causal? 1994

7 Comstock, Church Attendance And Health 1972

8 Oxman, Lack of Social Participation or Religious Strength, 1995

percent of the patients would die within the first six months after the operation so that a prospective study could look for factors influencing this mortality rate. Before the operation, the patients were asked about their religious attitudes and affiliations. In contrast to Comstock's study, these researchers were not only interested in the religious denomination or the attendance at religious functions but also in the subjective expression of faith. The patients were asked about their sense of religiousness and whether they would gain strength and comfort from their faith. The results were very interesting. Patients not participating in any social groups were four times more likely to die after heart surgery, and patients receiving no strength and comfort from religion were over three times more likely to die. The independence of these two phenomena indicates that faith was not simply important because it led to a stronger social connection. The risk for death from the combination of the lack of group participation and the absence of strength and comfort from religion was nearly three times greater than the risk for those only lacking group participation or only having absence of strength and comfort from religion. These results were independent from factors that have a known influence on mortality such as age, previous diseases, or smoking. This study was also epidemiologically sound and came to statistically significant results by excluding pure chance with more than 95 percent probability.

Some other studies provide further clues for the influence of spiritual factors on health. A group of researchers in San Francisco examined whether the change of certain behaviors could prevent coronary heart disease and reverse severe coronary arteriosclerosis. A control group received the standard education on healthy lifestyle ar diet, whereas the experimental group r ceived in addition education that containe stress management techniques includir meditation, progressive relaxation and in agery. The coronary circulation of the ex perimental group significantly improved a ter one year without the use of any lipi lowering drugs[9].

2.1.2 Influence of the Frequency of Malignant Tumors and Disease Outcomes

Religious affiliation and religious prac tice have a pronounced inverse correlatio with the incidence of malignant tumors i certain population groups as well as wit the progress of disease in individual pa tients. For many decades, it has been wel known in the U.S. that members of certai religious communities have significantl lower tumor rates than others[10]. The state o Utah, which is predominantly populated b Mormons, reports relatively low rates o lung cancer and overall a higher life ex pectancy. Similar effects can be shown fo other regions in which there is a high per centage of Protestant Christians. This corre lation probably relates to strict moral codes that discourage the use of tobacco and al cohol. Interestingly, this positive health in fluence is not only observed among the members of these religious communities but also among non-religious citizens of the same states probably because health dam aging behavior is discouraged in the entire community. Members of religious commu nities that are regarded as liberal with less strict behavior rules such as liberal Protes-

9 Ornish, Can lifestyle changes reverse coronary heart disease? 1990

10 Dwyer, The Effect of Religious Concentration, 1990

tants, Jews, and Catholics, however, experience tumor incidence only slightly below levels in the general population. After extensive research using the National Center for Health Statistic Data, the authors of this study conclude:

"Our findings suggest that religion has a significant impact on mortality rates for all malignancies combined. These results provide new insight into the relationship between religion and health at a macro or community level and suggest that the influence of religion on social structure warrants further attention"[11].

The avoidance of carcinogenic substances is certainly only one aspect of this phenomenon since the development of malignant tumors is a complex process. Another study about mortality rates and religious affiliation observes that

"studies have gravitated from a willingness to attribute all religious differentials in morbidity and mortality to specific health practices, such as smoking, to a broader view of social networks of support, inner attitudes which may be stress reducing, and the buffering nature of supportive groups when individuals encounter stressful life events"[12].

Many studies that examine not only the prevention of tumors but also the effects of individual attitudes and practices on the progress of disease confirm this observation.

A study that was published in the leading British medical journal *The Lancet* examined women who were suffering from metastatic breast cancer[13]. Even though recovery was virtually excluded at this late stage of the disease, researchers were interested in the effect of psychosocial interventions on the survival and psychological well-being of the patients. One group of women received a standard therapy; the other group an intensified psychosocial support including the formation of strong social networks in which the patients could reflect on the meaning of their disease by using their experience to help other patients and their families. On average, this intervention group lived twice as long as did the control group.

2.1.3 Psychiatric Diseases

Many studies address the relationship between religion and psychiatric diseases and conclude that a religious attitude and practice lead to reduced rates of depression, neurosis, and other diseases. However, other studies could not confirm this positive correlation so that the correlation cannot be conclusively established. An important question to consider is whether a religious practice leads to different reactions to stress. Seven hundred twenty people participated in a study that asked for religious affiliation and practice and tested the stress reaction and its effect on psychiatric diseases[14]. The study showed that people with a religious orientation were not experiencing less stress than others but were less affected by this stress. The researchers presented an interpretation that religious practice provides a kind of buffer so that

11 Dwyer, The Effect of Religious Concentration, 1990, p. 185
12 Jarvis, Religion and Differences in Morbidity and Mortality, 1987, p.821

13 Spiegel, Effect of Psychosocial Treatment, 1989
14 Williams, Religion and Psychological Distress, 1991

people can deal better with stressful situations. Therefore, they experience less symptoms of stress like depression, anxiety or psychosomatic difficulties.

2.1.4 Influence on General Life Expectancy

Many studies show a positive influence of religious affiliation and faith on the general life expectancy rate. A long-term study involving a whole county in California examined the influence of many factors on mortality rates. This study demonstrated that in Alameda County, persons belonging to a church had significantly lower mortality rates in all age groups than persons who did not belong to a church[15].

2.2 Religious Attitudes and Practices that have Beneficial Effects on Health

2.2.1 Membership in Communities and Social Networks

Membership in a strong community promotes health. This statement is neither new nor surprising, but it has been difficult to get conclusive scientific evidence to support this thesis. A human being is a social being and depends on contacts with fellow human beings. In fact, humans can only survive within a community. Social interaction begins with the smallest unity of community, the family, and extends to larger social networks. It has been long known, for example, that single or widowed men have a significantly higher mortality rate than married men.

Non-western cultures in Africa, Asia and Latin America demonstrate the importance of the community for the promotion of health. In these cultures, the individual is rooted in the community much more firm than in European cultures. This fact is th basis for the concept of community base health care, which has been accepted as th primary foundation of health care particu larly in developing nations. This type health care means that health is the prima responsibility of all people living in commu nities. The support and help, knowledge an skills they can offer to each other are the ma jor factors leading to improved health.

2.2.2 Social Networks that Care for the Sick

Living in community is important no only to prevent disease but also to over come diseases or to learn to live with them Many studies show that patients wit chronic or incurable diseases can deal bet ter with their condition and have a highe quality of life if they are part of a strong so cial network offering support and care.

2.2.3 Avoidance of Risk Behavior because of Moral Principles

Many religious communities support o even demand a behavior that avoids nega tive effects on health. Very often, member of religious communities consume less al cohol and tobacco, have fewer sexual part ners and are more averse to the use of illici drugs than comparable groups, even if thei denominations exercise relatively mild pressure on the behavior of their members All of these factors lead to a protection from certain diseases.

2.2.4 Worship and Rituals

Songs, prayers, sacred scriptures and rituals that are well known to people from their childhood have very positive effects. Consciously or unconsciously, they lead to a feeling of remembered well being and of fa-

15 Berkman, Health And Ways Of Living, 1983

miliarity and relaxation that can reduce stress[16]. Special rituals and symbols such as the anointing and blessing of the sick can be effective signs for the presence of God and comfort and empower people in their specific situations.

2.2.5 Prayer and Meditation

Prayer and meditation have multiple effects on physiological processes in the human organism. Studies show that meditation leads to a reduction of blood pressure and heart rate, less excretion of the stress hormone adrenalin and relaxation of the sympathetic nervous system. All of these factors protect various organs, particularly the circulatory system. Other studies show that prayer and meditation reduce muscle tension and chronic pain. In short, these religious activities reduce stress and provide positive effects on the whole body. These effects persist not only during the actual time of prayer or meditation but also for a longer period of time.

2.2.6 Meaning in Life

Without any doubt, a crucial factor for the health promoting effect of faith and religious practice is to help people find meaning in life. People who experience meaning and purpose in their lives not only find it easier to bear life's suffering but also find it easier to have the courage and the will that is required for life and sometimes even for survival. After his experience in the concentration camps of the Nazis during World War II, Victor Frankl, the Jewish psychiatrist and founder of logotherapy, has described the relationship between meaning and life[17]. He concluded that the loss of meaning was the most serious existential problem of our age. He regarded religion as one of the answers to this existential crisis. Of course, the meaning of life cannot be measured epidemiologically as easy as church attendance or religious attitudes. Therefore, the meaning of life is rarely addressed in the studies described above. Nevertheless, meaning might be the key for some of the phenomena that were observed and that might never be fully explained by empirical methods.

In summary, probably all the factors described above contribute to improved health. Health is a complex process that can never be adequately described by one or two parameters. Religious practice itself is also a complex process with undeniably positive effects on health.

3 Interpretation and Evaluation of These Studies

The question of how to evaluate the importance, validity and consequences of these studies remains. Are these studies important for churches and congregations in Europe? Considering that almost all of these studies have been conducted in the U.S., their relevance for other countries may be questionable. The social and religious contexts of America and Europe are significantly different. One important difference is religious affiliation. Surveys in the U.S. showed that 96 percent of all people believe in God and 42 percent attend a religious gathering at least once a week[18]. Therefore, the correlation between health and faith might be different in the U.S., where many people have a very

16 Benson, Timeless Healing, 1996
17 Frankl. Grundriss der Existenzanalyse und Logotherapie, 1998
18 Levin, Is Frequent Attendance Really Conductive to Better Health? 1987

strong commitment to practiced religion, than in the more secularized societies of Europe. At the same time, there is a multitude of different religious communities and practices that might influence conditions related to health. These studies show that in general, affiliation to a religious community leads to a higher sense of self-confidence and self-esteem in the U.S. It is an open question whether or not this correlation can also be assumed as relevant for Europe.

There are indications that simple membership in a particular church just for the social convention without any inner conviction has no positive effects on health and can even be detrimental. Only religious affiliation built on religious values and spiritual experiences may lead to the positive effects described in these studies. Furthermore, religious practice and faith can sometimes have negative effects on health. Psychiatrists know of so-called ecclesiogenic neurosis, which can occur when people feel tremendous moral pressure or feel that they permanently fall short of high moral expectations. Harold Koenig, a psychiatrist, has examined these phenomena and concludes that on balance, faith and religion have more positive effects unless religion is being misused in negative and damaging ways when people already have neurotic tendencies[19].

The perceived positive effects in these studies do not mean that the correlation between health and religious practice can clearly be regarded as causal or as scientifically unequivocal[20]. Certainly, more studies are needed particularly in Europe to confirm the preliminary results.

Currently, a number of scientists in the U.S. are working on further studies. It would be desirable to promote these types of studies also in Europe by bringing together physicians, epidemiologists, theologians and sociologists in an interdisciplinary dialogue that would enhance the current knowledge.

4 Summary and Application

In spite of the need for a careful interpretation of these epidemiological studies the results challenge the religious practice of churches and congregations. Practical theologians should ask themselves whether the strong correlation between faith and healing should have consequences for the practice of preaching, pastoral care and worship. These findings might influence the work in the congregations in special worship services that emphasize the aspect of healing in the form of prayer for the sick or in using rituals like the blessing of the sick and anointing with oil. People might benefit enormously from meditation exercises, self-help and discussion groups for patients, visiting the sick or seminars about self-promoting and self-damaging behavior.

These activities would also help with the interpretation and deeper understanding of the term "healing community" or "healing congregation" that has been discussed extensively in the ecumenical movement after the Tübingen Consultation in 1964[21].

In Germany, this term was received with skepticism because it was regarded as not relevant or as too demanding for the existing

19 Koenig, Is Religion Good for your Health? 1997
20 Levin, Religion and Health, 1994

21 WCC, The healing church, 1966

congregations. The dominant paradigm of a strict separation between theology and medicine or pastoral care and physical care contributed to this skepticism. This paradigm is beginning to change, and the churches should take notice of this development.

Finally, the epidemiological studies could revive the dialogue between medicine and theology because they use a language that at least the physicians can easily understand. Comparative studies using epidemiological tools are the foundation of clinical research and statistical analysis of certain factors on health and do not depend on any religious or philosophical preconceptions. The churches and the theologians should be encouraged to take up this theme with self-confidence and without any suspicion that their scientific credibility is questioned. Science increasingly shows that there is a positive correlation between faith and health and that a tremendous potential exists for a multidimensional approach to health by using the resources of various disciplines.

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Concepts for Church Related Health Care in the 21st Century

Christoph Benn

In many countries all over the world churches and faith based institutions are running hospitals and health care programs. Traditionally it was their mission to serve particularly the poor and those who had not sufficient access to other services. But increasingly this mission is jeopardized by financial pressures and other constraints.
This article will look at the most important concepts in international health that were developed over the last decades such as primary health care and its current relevance for church related health services. Different models for health care financing are introduced. However , it is claimed that the maintenence of institutions cannot and should not be the most important goal for Christians. Rather they should renew their vision and look for the best ways how people can attain their full potential and highest possible level of health given the limitations of the current world economic order. This level can be achieved but only if Christians and non-Christians alike will practice global solidarity and recognize the implications of the universal human right to health.

1 Historical Background

All over the world, church related health care institutions are confronted with tremendous challenges in regard to their justification and organization. This article will concentrate mainly on health services in the less affluent countries of Africa, Asia and partly Latin America. However, we should not overlook the fact that there are a lot of common problems and concerns between institutions in industrialized and in developing countries. Not only do they share a common history as their origins go back to the 19th century, when churches in the North began to address social needs in their own countries, as well as in their missions overseas. But also other concerns are very similar. Health care services of the churches receive their theological justification from the healing ministry of Jesus Christ. Christians are commissioned to care for the poor and destitute in their particular societies. In industrialized and developing countries they are confronted with competition from government and from private for-profit institutions. Finally they are facing severe financial problems and the necessity to improve their efficiency and quality.

1.1 Health Care Services during the Period of Colonialism

Health care services in countries being under European administration during colonial times were mainly composed of two elements:

First, the provision of curative services for civil servants and a small indigenous elite, mainly in the major cities and areas of economic interest.

Secondly, mission societies founded hospitals and health centers, particularly in the rural areas. In the beginning, an important motivation for these services was the protection of their missionaries' and co-workers' health. But gradually the provision of health services for the local population became more important.

1.2 Health Services in the Independent Nations of Africa and Asia

With the independence of many African and Asian countries in mid 20th century, the situation changed dramatically. The young nations took over the existing institutions of colonial time including the model of a scientifically based medicine. They built on the existing hospital structure and extended it considerably. In the early years they depended very much on foreign professionals, because indigenous doctors and nurses where not yet trained in sufficient numbers.

Particularly in Africa, but also in Asia there was a kind of division of labor between the state and the churches. The state took over the institutions of the colonial administration which was concentrated in the urban centers and included the secondary and tertiary level of health care up to university level. This part of the health system was particularly expensive so that in some countries up to 80 percent of the whole health care budget was allocated to the university hospital usually situated in the national capital. The provision of health care for the people in the rural regions where the majority of the population was living was largely left to the churches and charitable organizations. They could rely on quite a number of missionary hospitals, and the responsibility for running these institutions was handed over from the mission societies to the newly established national churches. With the help of partner organ zations in the North, even new institutio were built and health professionals we sent to support their partner churches the extension of this network.

1.3 New Challenges

Already in the sixties governments an churches were challenged to rethink the concept of health care. Studies had show that only about 20 percent of the populatio had access to hospitals and health care cen ters, where modern medicine was prac ticed. The rest continued to depend on tra ditional healing methods or had no acces to any form of organized health care.

It also became increasingly clear, tha hospitals alone could not change any of th factors leading to poverty and disease. Wit regard to the health care status of the popu lation, relatively little had been achieved – in spite of a considerable input of man power and financial resources. Christia health professionals discovered their call t leave the hospitals and to provide wholisti health care for those who were disadvan taged and had no access to social services They saw that they had this particular obli gation to improve the health of poor people living under desperate conditions, suffering from malnutrition and many other predica ments. In order to achieve this objective they developed a new approach which em phasized the participation of the people concerned, going far beyond the provision of services by professionals. It was realized that even people without any former train ing had a lot of skills to improve their health and the social conditions in their communities. Therefore the new concept promoted community participation and community ownership. Health care based

on scientific knowledge was still part of the system, but had to be adapted so that all people could benefit from these services. Instead of hospitals that copied the western model, hospitals and health centers with simple but effective equipment were required. Charismatic personalities took the lead in developing and practicing this new type of health care provision in poor communities. Some of the most outstanding examples were Carroll Behrhorst in the Chimaltenango-Project in Guatemala and the Aroles in Jamkhed in India.

Many of these innovative projects were part of the healing ministry of the Christian churches. The newly founded Christian Medical Commission of the World Council of Churches in Geneva collected and published many of these concepts stimulating others to apply them in their own context[1]. Many countries also promoted alternative concepts of health care as for example the barefoot doctors in China or the training of village health workers in Tanzania.

Also the World Health Organization took a great interest in this issue and published many of the early examples of community based health care in a book called "Health by the people[2]". This global movement led to a new concept of health care that differed in many aspects from the dominant philosophy of health care provision. At an international conference in Alma Ata in 1978 which was jointly organized by WHO and UNICEF, the new concept of Primary Health Care (PHC) was formulated. It was adopted by the large majority of member states of WHO at the following World Health Assembly. Through PHC an attempt was made to provide access to health care to all people particularly in the less affluent countries providing essential curative services and putting a strong emphasis on the prevention of diseases and premature mortality. It has become the basis of health care for the majority of the world population even if the implementation of this concept has often been quite difficult. In the declaration of Alma Ata health was described as a fundamental human right and particular efforts were called for to make sure that this right would become a reality for all people.

Primary Health Care was defined as:

"Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of the development in the spirit of self-reliance and self-determination."[3]

To achieve this goal eight essential elements of PHC were developed:

1. Education concerning prevailing health problems and the methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation

1 CMC: The Principles and Practice of Primary Health Care, 1979
2 Newell, Health by the People, 1975
3 WHO, Alma Ata 1978 – Primary Health Care, 1978, p. 3

4. Maternal and child health care including family planning

5. Immunization against major infectious diseases

6. Prevention and control of locally endemic diseases

7. Appropriate treatment of common diseases and injuries

8. Provision of essential drugs

These elements show that PHC is a mixture of curative and preventive approaches. But they are no longer primarily dependent on a hospital structure but can be implemented in small health centers or even by so called village health workers. The factors leading to ill health are to be addressed not only in the context of the individual patient but in the context of the social environment.

One year after the conference in Alma Ata WHO proclaimed a new goal for its activities: "Health for All by the Year 2000". Obviously the people who formulated this slogan did not have the illusion that diseases would be eradicated on this globe by the year 2000. It was a political program indicating that with joint efforts using the available knowledge and technology it would be possible to provide all people with essential health services according to the definition of PHC, even in countries with poor resources by the year 2000.

The definition of "Health for All" was:

"The attainment by all peoples of the highest possible level of health; and that as a minimum all people in all countries should have at least such a level of health, that they are capable of working productively and of participating actively in the social life of the community in which they live."[4]

1.4 The New Philosophy of Health Car

PHC was not meant to be a model deve oped only for poor nations until they coul afford a better system. It was rather a ne philosophy changing the thinking abou health and disease.

Health and disease are processes of huma life which we do not posses and over whic we ultimately have no power. We can only in fluence the factors leading to more or les disease. One of these factors is medical car in the curative sense. PHC emphasizes th maintenance of health and the prevention o disease. This can only be achieved by influ encing in a comprehensive way the socia conditions under which human beings live.

The following factors are part of this new thinking:

- self-reliance
- social equity
- care according to need
- community orientation instead of individualistic health care
- maintenance of health and not only treatment of diseases

After Alma Ata many communities and countries began to implement and practice PHC. In spite of the early enthusiasm it became obvious that this concept was not ye a guarantee for an appropriate health care system that was accessible and affordable for all. Many of the trained village health workers put their emphasis again on the distribution of drugs, and some of them stopped working when the governments would not provide them with decent salaries and the communities were not able

4 WHO, Global Strategy for Health for All by the year 2000, 1981, p. 15

to support them. Multisectoral cooperation which was a cornerstone of PHC proved to be very difficult to implement in practice and generally PHC was poorly financed. Neither did national health budgets redistribute resources from the higher levels of health care to PHC, nor did the international community and the donor agencies support PHC sufficiently.[5]

Furthermore, the PHC model was facing strong resistance from different sides. It was perceived as a threat to existing institutions, beginning from the medical schools to the administration in the health ministries to the pharmaceutical and technical industry and not the least to the professional organizations of physicians. This was hardly surprising as it had been the stated goal of PHC to take privileges and competencies from these institutions and to give it to people who were not considered to be qualified to do this according to the previous model. Therefore up to today this model has been implemented only partly, although there are no reasonable alternatives in the current world economic system. Particularly doctors coming from wealthy countries and being trained exclusively in the curative system, but who are going to work under totally different conditions in poorer countries, would have to consider carefully which model they want to support through their work and example.

2 The Current Situation at the Beginning of the 21st Century

The health situation in most of the low income countries is still characterized by a low life expectancy and high child mortality rates leading to the sad fact that every year about 12 million children die of preventable diseases. Maternal mortality is very high, exceeding in many African countries industrialized countries' rate by a factor of more than 50. The causes for these unfortunate health data are to be found in the lack of access to quality health services, drugs and comprehensive health programs but also in the lack of safe drinking water and sanitation, in malnutrition, insufficient knowledge about health and poor living conditions.

It is of crucial importance that this tragic situation causing human suffering and premature death is addressed as urgently and comprehensively as possible. Governments, churches and other members of civil society will have to work together to overcome the obstacles to the highest attainable standard of health for all people. Fortunately the knowledge about effective interventions to improve health has been increasing considerably over the last decades. Immunization campaigns, oral rehydration, integrated management of child health and other interventions can lower child mortality considerably, well organized Tuberculosis, Leprosy and HIV/AIDS programs can reduce infection rates as well as morbidity and mortality.

These programs should go hand in hand with community based initiatives. Communities can be empowered to contribute greatly to their own health and development. They should define themselves where their problems are, they have to participate in the planning and implementation, financing and evaluation of all programs promoting health. The old dichotomy between selective and comprehensive primary health care, between top-down and bottom-up approaches should not be maintained any

[5] Tarimo, Primary Health Care Concepts, 199-

longer. In actual fact we need both elements and a good integration of community based health care and functioning health systems able to apply effective and scientifically proven interventions. This comprehensive approach is not in any way contrary to the original intentions of the Alma Ata declaration but has been emphasized early on in the debate even by some of the pioneers of the primary health care movement.[6]

Building on this foundation of community based health care, comprehensive health systems will consist of a pyramid of various levels, including village health workers, the health centers, district hospitals, and finally the referral hospitals on the secondary and tertiary level.

2.1 The Role of Hospitals

The hospitals continue to play an important role in the PHC system, but not the dominating one. Hospitals tend to emphasize the curative and technical side of health care. Therefore any comprehensive health care program can not only rely on hospitals. But at the same time it is evident that there can be no successful PHC program without the cooperation and participation of hospitals. They are important centers for the training of health care workers who are going to work in the villages and communities, and they are important as referral centers to which other levels of the health care pyramid can refer the patients who can not be cared for at the lower levels. By providing good curative care they increase the trust of the communities in the comprehensive system and are therefore a very important part of it.

This applies in particular to the distri hospitals which have a central role in t concept of WHO for a district health syste They are the link between the commun based health care on the one side and t teaching and referral hospitals on the oth side[7]. Many of the mission hospitals, parti ularly in Africa, have taken over this impo tant role as district centers for curative ar preventive care. The future relevance mission hospitals will depend on how muc they will be able to play this integrating ro at district and sometimes regional level ar how much they will participate actively the implemention of national health pr grams (Safe motherhood, integrated chil care, malaria control, TB, HIV/AIDS etc.).

3 The Financing of Health Care Service

Currently the health services in Africa ar in a phase of restructuring, looking for su tainable solutions to provide quality ser ices for all people. Economic decline, wors ening conditions on international marke and the structural adjustment programs the World Bank and the International Mon etary Fund have led to a dramatic decreas of health care spending by many Africa governments. Following these reductions many countries have introduced reform leading to a strong decentralization of serv ices and a shift towards the private sector.

But also the Church hospitals can not b maintained just by the churches themselves They are depending on support from th government, whose ministries of healt usually provide parts of the running costs o Church institutions to a varying degree. I principle both government and church in

6 Taylor, The Straw men of PHC, 1988

7 Amonoo-Lartson, District Health Care, 1984

stitutions are financed through different sources: tax revenues, direct fees of the patients and donations from international partners. Unfortunately this model has become more and more insufficient. Tax revenues in developing countries are often very low and the use of them is not very efficient. The ability of poor patients to pay fees for service is rather limited and leads to the exclusion of the most needy persons from necessary services. The hospitals are facing a dilemma. If they increase the patient fees, the user rate decreases and finally even the income will go down. If they do not increase the patient fees, their services will not be sustainable. Even the support from international donors and institutions has been decreasing over the last couple of years. Therefore there is an urgent need to look for new ways of financing health care services in countries with limited resources.

3.1 Asia

Asia has a special place in the history of the Christian health services. The origins of medical missions were mainly in China and India. Many mission hospitals were founded in these two countries, and also the pioneering projects of the PHC movement took place largely in China and India[8]. But also the greatest crisis of medical mission originated in Asia. After the revolution in China in 1949, all mission hospitals in this country were closed, which was a shock for the international missionary movement. In India, many church hospitals had to face strong competition through government and private institutions after independence. Christians in India are a small minority with limited resources, and the government restricted the transfer of resources form western countries. Because of this situation, 600 out of originally about 900 church hospitals in India have been closed by now. This has been a painful process but also a learning experience. As a reaction to this changed situation, most of the remaining institutions tried to adapt to technological developments investing in modern high-tech devices in order to attract well paying private patients. Ideally these efforts could help to acquire a sustainable income and to gain a surplus that could be used for the treatment of the poorest patients. Similar attempts are being made for example by church hospitals in Indonesia.

Although this model sounds quite attractive, it very often creates difficulties for the hospitals and its understanding as being part of the healing ministry of the churches. If the hospitals try to fulfill their calling to provide quality services for people in greatest need, they will run into financial problems. If they mobilize additional financial resources by moving into the high-tech sector of health care, they will attract well-paying members of the middle and upper class, but they will become inaccessible for the poor population. This is the main challenge for a church-related health institution, not only in Asia but worldwide.

3.2 Africa

In Africa, hospitals are financed through the three components described above: direct payments by the patients, government subsidies and donations from international partners. In some countries governments acknowledge their social responsibility and the role of the churches by supporting them with parts of the running costs. The subsidies vary between 5 and 80 percent, depending on the ideology and resources of

[8] Grundmann, Gesandt zu heilen, 1992

the particular state. In any case, direct patient fees are important for almost all church hospitals. They introduced this mechanism often long before governments implemented fees for service programs. The contribution again depends on the financial resources of the communities, and usually provisions are being made for very poor patients. The third component -donations from international partners- concentrate mainly on capital investment like extension of buildings, renovations, purchase of cars and other equipment. Furthermore the secondment of skilled personnel can also be regarded as a direct contribution. For many years donors have been reluctant to support running costs like salaries, consumables and drugs, in order to promote sustainability and self-reliance. However, exceptions from this principle have always been made and it is questionable whether the separation between investments and running costs can be maintained in the future.

In general, the financing of church hospitals in Africa is in an acute crisis because to a varying degree all three sources are currently diminishing[9]. Many governments are not able or willing to maintain their investment in health care either because of deteriorating macroeconomic conditions or because health received less priority. The subsidies for church hospitals often suffered disproportionally in this situation. At the same time the impoverishment of rural populations reduced their ability to pay for modern health care. Finally, regular support through international development aid appears also to be an unreliable and non-sustainable way of financing hospital services. New approaches like communi based health insurance are only gradual gaining importance.

3.3 The Concept of Community Based Health Insurance

An attractive alternative seems to be th model of community based health insu ance. It is based on risk sharing and r source pooling and has worked fairly we in many industrialized countries. In rece years, several pilot projects have been init ated in sub-Saharan Africa trying to tran late this concept into reality.

Many international organizations lik WHO, ILO and the World Bank have show great interest in this approach and pub lished manuals to promote its implementa tion[10]. Several of the existing schemes hav already been evaluated so that lessons ca be learned from the ongoing experience The main lessons learned for communit based health insurance are:

- Insurance schemes need a clear gov ernment policy and legal framework.
- The framework needs to be adapted t the local and national situation.
- Pilot projects can help to develop a na tional policy on health insurance.
- Insurance schemes cannot replace national health system, they can only con tribute to it.
- The introduction of health insurance might have negative effects for those people who for different reasons cannot join any o the schemes. Therefore mechanisms should be introduced to reduce inequities and en sure access for the poorest sections of com

9 Flessa, Costing of Health Services,1997

10 Bennet, Health Insurance Schemes, 1998; Normand, Social Health Insurance – A Guidebook, 1994; Shaw, Financing Health Services through User Fees and Insurance, 1995

munities (sliding scale fees, exemption policies, subsidies).

- The potential for cost-recovery in rural areas is limited. Insurance schemes cannot solve the financial problems by themselves.
- Insurance schemes should rather be seen as an additional instrument for financing essential health services.
- Government subsidies will be required even for well designed and efficiently run insurance schemes.
- Insurance schemes are not only instruments for getting additional funds but can improve the sense of community participation, ownership and responsibility.
- A split between provider and purchaser of health services is preferable for any community based scheme, but depends on the availability of different providers so that the consumers have a choice.
- A detailed understanding of people's preferences, needs, ability to pay etc. is essential to design a scheme. This can be achieved through feasibility studies.
- Communities need to be well informed about all aspects of insurance schemes before they can be initiated.
- Well designed schemes need to be marketed so that the highest possible number of purchasers can be motivated to join.

If these criteria are applied, health insurance schemes might make a useful contribution to the financing of health services in Africa in the future. But so far, this is just a model being practiced in some pilot projects so that their potential for short term benefits should not be overestimated.

3.4 Hospital Management

Arrangements to improve the efficiency and quality of hospital services are a precondition for the introduction of health insurance schemes and a necessary requirement for the improvement of the financial situation. Relevant concepts have been developed particularly in the USA and been given the name "Managed Health Care". Although it is definitely difficult to apply this concept to countries with different health care structures and resources, some church related health services have already tried to introduce certain aspects of Managed Health Care.

The Medical Department of the Evangelical Lutheran Church in Tanzania published a handbook that was intended to help its hospitals to implement more efficient structures[11]. Among others, these arrangements led to more transparency, quality assurance and a more efficient use of skilled personnel. But good management is more than a few administrative skills and techniques. Church institutions need to promote a truly Christian motivation that can be described with the terms stewardship, honesty and responsibility. The best management systems will be useless if money is not being spent correctly or if positions are filled not according to the criteria of qualifications.

Steffen Flessa, who has done extensive research on hospital financing in Tanzania, rightly pointed out that an improvement of efficiency will not necessarily lead to health services that offer good quality and are affordable and accessible for all. Even under the condition of optimal management and subsidies from partners in the North, it will be very difficult to maintain a health system based on hospitals following the Western model. The two alternatives are either a drastic increase in support from more wealthy countries or

11 Bura, Community Health Funds and Managed Health Care, 1999

the reorientation of the church related health infrastructure toward the principles of PHC. Flessa comes to the conclusion:

> "Church hospitals in Africa should find their place as supporting units for primary health care programmes."[12]

We have to consider another factor. In the end both, government and voluntary agency hospitals are heavily subsidized by public funds. This is justified because otherwise the poorest members of society would not have access to modern health services. However, the question is how the public funds are spent and who benefits most. Studies of the World Bank and WHO have shown that it is the better-off middle class who benefits most from subsidies to hospitals. The least advantaged are unfortunately less likely to benefit from this kind of subsidy. It is worrying that this situation seems to apply even more to church related voluntary agency hospitals than to government hospitals. This means that the rich benefit more from public and charitable donations than the poor. Therefore the study recommends that subsidies should be much more targeted.

"It is safe to say that targeting health spending to the poor in Africa would require spending less on hospitals and more on primary facilities."[13]

These analyses emphasize again that churches should not try to provide health services for entire populations. That is the role of the governments. Church hospit are still important if they fill an obvious g and are part of a district health service th is recognized and supported by the gover ment. But if this is not the case, if there a already a sufficient number of hospital bed if churches are even competing with ea other and if the service to the poor is not t priority of the facility, then there should no role for the church to be involved. such a situation the churches' witness to t gospel might rather be hampered and th should not be afraid of closing down faci ties even if this would be a painful proce given the often longstanding tradition some of these institutions and the presti that is involved with hospital services.

4 Promotion of Innovative Projects through a Scaling-Up Process

Carl Taylor, one of the pioneers of th PHC movement who greatly influenced th formulation of the Alma Ata declaration, ha recently published a new approach de signed to promote innovative projects help ing them to reach more people by a scaling up process[14]. He assumes that in almost a countries there are innovative communit projects which could be of great relevanc for the health of the people. Those might b agricultural cooperatives, microcredi schemes, initiatives to protect the environ ment, faith communities or health pro grams. The presence of such a communit initiative and motivated people is sufficien to start a development process that can be used to promote health. The first step is to identify these projects:

12 Flessa, The costs of hospital services: a case study, 1998, p. 406

13 Castro-Leal, Public Spending on health care in Africa: Do the poor benefit? 2000, p. 69

14 Taylor, Community Based Sustainable Human Development, 1995

SCALE One: Selecting Communities As Learning Examples

These projects should be supported so hat other communities can learn from their example spreading the idea in the whole region and thus leading to the second step:

SCALE Squared: Self-help Center for Action Learning and Experimentation

If they achieve extensive participation of the people, the projects can expand to different areas (agriculture, health, environment). People become aware of their own potential and capacities to change their living conditions comprehensively. They are now free to develop their own priorities and methods and by doing this will become a new model for others.

After the successful implementation of the second step the project might serve as a national or even international training model that can eventually change the attitudes of leaders and experts. Part of the third step is the creation of a training center that can combine applied research with experiential learning.

SCALE Cubed: Sustainable Collaboration for Adaptive Learning and Extension

Carl Taylor and his son who is the co-author of this study argue that successful pilot projects like Jamkhed in India have followed this process. Jamkhed is now an international training center influencing similar approaches all over the world.

The churches have a great potential to support this kind of development processes. Many excellent community based initiatives have been started by committed Christians who are trying to serve their communities. In the future it will be important that churches identify, recognize and support these initiatives. This might demand a high degree of flexibility and willingness to accept innovation. But they could become an essential contribution to human development and health, probably more than through the maintenance of inefficient institutions that have lost their vision.

Many Christians are engaged in projects focusing on the most pressing social needs which government-run programs are finding difficult to deal with. There are examples all over the world of initiatives serving drug users, people living with HIV/AIDS, urban slum dwellers, or working among refugees and ethnic minorities. This kind of health work expresses very clearly the calling of Jesus to discipleship in the service of the poor, the needy and the sick. This should be the main focus of church related health work also in the future, in developing as well as in industrialized countries.

5 The Role of Partners in the North

The relationship between churches and development agencies in the North and their partners in the South is characterized by the principle of subsidiarity as is the relationship between church and state. Partners in the North cannot and should not take over the full financial or administrative responsibility for health institutions in the South. Not only are resources not available

for such a broadranging effort, but in particular both sides have to take care that all services be delivered in a way that is culturally sensitive and responsive to the local community. However, international partners can and should support useful and well designed programs contributing to better health particularly for the least advantaged, as long as these efforts cannot be maintained with local resources alone. The churches all over the world regard these efforts as the implementation of Jesus' commandment to love our neighbor. By taking part in this ministry of healing they practice global solidarity and become part of God's mission in this world.

Under these conditions, livelong secondments of missionaries will be the exception rather than the rule. Longterm engagements of expatriates can lead to dependencies and inhibit initiatives of local counterparts. On the contrary, Christians should be prepared to work in solidarity with their brothers and sisters overseas to be witnesses for the common vision and mission across borders and continents. In a world constantly becoming smaller and interdependent, this can lead to a temporary cooperation and exchange of personnel between partner churches if there is a particular need for certain professional skills or qualifications which could not be obtained locally. This form of a missionary calling will also be required for the foreseeable future.

Apart from the exchange of personnel and the conceptual and financial support for projects it will become increasingly important to influence the global economic and political framework that is currently inhibiting development. Partners in the North have a crucial role to play as advocates for the South within their own societies ar with their own governments. Examples this advocacy role are the Jubilee 20 campaign for debt relief, the 20/20 initiati trying to increase the resources for bas social services, or the newly founded Ec menical Advocacy Alliance focusing globalization and the HIV/AIDS pandemi In each of these examples a close and trus ful cooperation between members of th civil society in the North and the South ha been of utmost importance.

Finally, people living in affluent countrie have to understand that global solidari and cooperation is in the interest of bot partners and a necessity for peaceful coexis tence in our world today. There are man good reasons for this global partnership Apart from the specific Christian motivatio it is the call for justice and equity based no only on ethical demands but also on th recognition of universal human rights. Eve secular people today emphasize the univer sality of human rights for all human being independent of ethnic origin, culture, reli gion, social status or country of birth Therefore the advocacy campaigns of th churches should point out the urgency o the full implementation of political and so cial human rights. In the future, this empha sis will be an important component o global politics and development cooperation in order to achieve sustainable and healthy living conditions for all people on our globe

6 The Right to Health

An essential element of the social human rights is the right to health[15]. Already the Universal Declaration of Human Rights

15 Center for the Study of Human Rights,1994

adopted by the United Nations General Assembly in 1948 declared in Article 25:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care."

The International Covenant on Economic, Social, and Cultural Rights which transformed the declaration into international law further elaborated on the specific right to health care in Article 12:

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Of course, the right to health is no entitlement to physical or mental perfection but a right to the highest standard an individual could attain. In particular, the right to health is a duty for governments to provide for, to promote and to protect conditions under which human beings can develop their full potential of health which is very different interindividually. We can speak of a right to appropriate health care only as a part of the general right to health. It refers to the duty primarily of governments to provide health services. Therefore the International covenant continues in Article 12:

"The steps to be taken ... include those necessary for:

The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

These considerations introduce a new aspect of the ministry of health and healing. Churches and development agencies contribute to the gradual realization of an essential human right in economically disadvantaged countries. They share in the great task to work toward the global goal that people all over the world can develop their full potential in terms of health. The knowledge that health is a crucial precondition for socio-economic development should further increase our efforts in this respect. They will also urge citizens and governments in more affluent countries to share their wealth and bridge the glaring gap between the haves and the have-nots in our globalized world constituting a gross violation of the principles of justice and equity.

Christians will do this as disciples of Jesus Christ and in the conviction that every human being on earth has been created in the image of God and is our beloved neighbor whose destiny cannot leave us indifferent. But they will also remind their secular contemporaries that health is a basic human right and that we simply cannot afford to live in a world that provides a social safety net only for those who were lucky enough to be born in wealthy societies and who in addition benefit most from the current economic globalization. Therefore cooperation for health and development is not only an act of mercy but a dire necessity and an obligation demanded by social and economic common sense and by the respect for the universal human rights.

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Participating in God's Salvation Activities in the World

A Shift in the Understanding of Mission

Beate Jakob

The criticism of the missionary practice of the Western churches in the second half of the 20th century gave the impetus for a change in the theology of missions. The Protestant churches developed the Missio Dei approach in the sixties. The different understandings of this model precipitated the ecumenical-evangelical controversy. The "Lausanne Covenant" (1974) represents the evangelical position while the document "Mission and Evangelism" represents the ecumenical position. The Second Vatican Council developed the interpretation of missions within the Roman Catholic Church in the apostolic epistle "Evangelii nuntiandi" (1975) and in the encyclical "Redemptoris Missio" (1990). The changes in the understanding of missions decisively influence the relationship between Christianity and other religions and impact inter-religious dialogue and the notion of remote cultures.

1 Introduction

The term "missions" denotes the organized activities and efforts of spreading the Christian faith and has only been used since the 17th century. With this meaning, this term lacks an exact equivalent in the Greek language of the New Testament.[1]

Even though the New Testament lacks conception of missions as an organize missionary work in a foreign country, nevertheless provides the essential conce tions for such work. God sends Jesus ar gives him a mission. Jesus then gathers pe ple whom he sends out with a mission. H commands, "Go therefore, make disciple of all nations" (Mt 28:19) and "You will b my witnesses" (Acts 1,8; cf. Lk 24,48) ar "As the Father sent me, so am I sendir you" (Jn 20,21).

For Jesus, both the gathering of peop and the sending them out with a mission ir trinsically belong together. The mission c the disciples and our mission as Christian extend and continue the mission Jesus fu filled for his Father. The term "missions describes the historically based and cor crete fulfillment of the commission Jesu asked us to accomplish.[2]

Today, the term "missions" evokes un easiness in many people, and for som "missions" has even become an emotiv word. Very often, the term "missions" i avoided in the names of some study groups journals, or institutions. The contemporar diverse criticism of missions is, however principally directed neither against the mis sionary character of Christianity nor agains Christians themselves but against the form or paradigm of missions that has character

1 Amstutz, Kirche 12; Pesch, Voraussetzungen 12-14

2 Cf.: Bürkle, Missionstheologie 20

ized the image of missions during the past centuries. Specifically, this criticism focuses on the "practice of Western missions in the past and in the present."[3] Some accuse Western missions of being a one-way street that reflects the "white man's arrogance"[4] and "a kind of triumphalist expansion of the Church."[5] These critics identify Christian missions with the colonialism of the past[6] and accuse such missions of being allied with colonial expansion and oppression and of destroying indigenous cultures, social structures, and religions and of creating an alienated church as well.[7]

Such criticism compel Christians to rethink their practice of missions and to develop a new understanding of Christian missions.

Rethinking missions is the subject of the present essay. Section 2 discusses the ecumenical and the evangelical analysis of the understanding of missions. Section 3 describes missions within the Roman-Catholic Church. Section 4 describes some consequences of the understanding of missions, and section 5 summarizes the development of the understanding of missions and describes the position of DIFAEM in this discussion.

3 Collet, Missionsverständnis 26
4 Bürkle, Missionstheologie 29
5 See: Collet, Missionsverständnis 27
6 Ibid. 28
7 Ibid. 34

2 The Understanding of Missions in the Ecumenical-Evangelical Discussion

2.1 The Initial Situation: Different Objectives of Missions

At the beginning of the 20th century, the various Protestant groups espoused different objectives of missions:

Anglo-Saxon Protestant missions sought to establish the Kingdom of God while German Protestant missions, influenced by Pietism, primarily aimed at the conversion and salvation of individuals.

For a significant number of German missionaries, however, the purpose of missions was to expand the Christian church. They referred to Gustav Warneck's definition of missions: "We understand Christian mission as the efforts of Christians worldwide to establish and organize the Christian church among non-Christians."[8]

Even though they espoused different missionary objectives, all these various groups nevertheless understood missions as "foreign missions," i.e., the efforts of Western churches to spread Christianity in non-Christian countries.

2.2 New Approaches in the Understanding of Missions

2.2.1 From Western Missions to Worldwide Missions

The modern ecumenical movement, which was initiated during the Edinburgh Conference on World Mission in 1910 demonstrated the need to transform the un-

8 See: Hering, Missionsverständnis 21

derstanding of Christian missions. This conference assumed the superiority of the Western Christian world over the rest of the world and marked the "climax of triumphant world mission."[9]

The succeeding conferences of the International Mission Council (IMR) are also called World Mission Conferences and took place in Jerusalem in 1928, in Tambaran (India) in 1938, and in Whitby in 1947.

These conferences mark the transformation from "western missions" to "world missions." This transformation resulted from the two world wars, which shook the self-confidence of the west, as well as from the secularism that increasingly spread across the Western world. This secularism erased the distinction between "mission countries" and "Christian countries," a distinction that had been so important to Christian missions since the 17th century. This transformation also resulted from the increasing strength of mission churches that objected to the title "offspring churches" and demanded more independence from the "mother churches." Participants of the Whitby Conference of the IMR no longer spoke of "mother churches" and "offspring churches" but of "partners of obedience."[10]

At the first plenary assembly of the World Council of Churches in Amsterdam (1948), the participants refused to differentiate any longer between inner and outer missions because the missionary activity in Christian countries did not differ in principle from non-Christian countries.[11] Participants of the IMR conference in Willingen in 19 reached a similar conclusion. This transfo mation from western missions to wor missions refocused the conversation abo missions around the conception of missio to the continents. The mission conferen in Mexico City in 1963 articulated this ne conception as the churches' moving towa the world in six continents.[12]

2.2.2 Missions as Missio Dei

The missions work of the weste churches in the first half of the 20th centu had been severely criticized. The climax this criticism was the expulsion of all Chri tian missionaries from China in 194 These events necessitated a radical chang in the conception of missions. The definin question was how to justify Christian mi sions. Participants in the world missio conference in Willingen in 1952 addresse the topic "The Missionary Commitment the Church." Discussion of this topic pre cipitated a "copernican change in th meaning of mission"[13] and justified the Mis sio Dei approach.

The two theologians Karl Barth and Jo hannes Christiaan Hoekendijk laid the theo retical foundation for the Missio Dei ap proach.

For Barth, revelation means self-revela tion. God is for him the only one who reall acts in the process of revelation. In relation to missionary work, Barth's conception o revelation means that God is the only one who is active. So, God's nature is at one and the same time both revealing and mission ary. According to this understanding, the

9 Was heißt Mission? 14
10 Cf.: Werner, Mission 62f
11 Üffing, Kirche 22

12 Hering, Missionsverständnis 86
13 Werner, Mission 66

human task is to give testimony, and God uses humans for God's purpose in the process of missionary work.[14]

Hoekendijk was the first secretary on questions related to evangelization in the study department of the World Council of Churches (1949-1952). At the conference in Willingen, he warned against missions strictly in terms of the church and pleaded for the avoidance of the conception of the church and the beginning and end of missionary work.[15] According to Hoekendijk, the aim of all missionary work is not to fill the world with churches but to confront the world with the demand for God's kingdom.[16] The ideas advanced by Barth and Hoekendijk formed the basic foundation for the Missio Dei approach to missions.

According to the Missio Dei approach to missions, God sends Son and Spirit and thus opens Godself to the world. The legitimation for missions flows from the essence of God. God is the one who sends, and each human's sending (sender) participates in the divine sending. In order to carry out God's sending plan, God makes use of people, especially the church. So, missions is not simply an activity of the church. Missions is part of the church's essence and also characterizes each individual Christian.

According to the Missio Dei approach, missions is located no longer in soteriology (missions to save souls) or in ecclesiology (missions to plant churches) but in the Trinitarian understanding of God. This theological understanding of missions means that missions is part of the essence of God in that God is a missionary God. This understanding of missions as part of the Missio Dei defends Christian missions against those who question their legitimacy.[17]

The Missio Dei approach demonstrates that the church's essence is missionary. Thus, missions cannot be basically questioned. The church "does not take part" in missions, it "is" missions. The term Missio Dei was quickly accepted after the conference at Willingen and became a generally accepted part of discussions about missions.

Two different models explaining how God's sending could be effected quickly arose.

Georg F. Vicedom advocates the first model. This model is based on the history of salvation and holds that God sends Jesus Christ into the world as the true missionary and that the church continues Jesus' mission. This model sharply differentiates the history of the world from the history of salvation. The history of the world is irrelevant; the only history that matters is salvation history. According to this model, God sent Jesus to rescue the church from a corrupt world that is perishing.[18]

J. Chr. Hoekenijk advocates the second model. This model is based on the history of promise and conceives of the Missio Dei much more inclusively than the first model. According to this second model, God's will to heal (cf. 1Tim 2,4) and the Christ event has already brought healing to all creation and to all human beings. God sent Christ

14 Bosch, Mission 390, Wrogemann, Mission 89-104
15 Bockmühl, Missionstheologie 14-16; Werner, Mission 63-66
16 Grundmann, Welt 132
17 Ahrens, „Mission" 123
18 Cf.: Vicedom, Missio Dei 70-72

not only to rescue the church but the entire world as well. This model abolishes the dichotomy created by the first model between the history of the world and the history of salvation.[19]

Since the 1960s, Protestants have vigorously discussed these two models and become divided over the issue of which model is preferable.

The **evangelicals** are primarily influenced by the history of salvation model. For them, redemption is only possible through the conversion to Christ, and the world outside Christianity is unredeemable. The gospel is the highest authority, and orthodoxy, the vertical dimension of faith, is stressed. Missions is first of all a propagation of the gospel and does not aim to change the structures of the world.[20]

The **ecumenicals** in contrast are primarily influenced by the history of promise model. Because of their conviction that God has saved the whole world through Christ and that God desires the healing of the world within history, they stress the horizontal dimension of missions as the humanization of the world. Neither the evangelicals nor the ecumenicals denies that the vertical and the horizontal dimensions of missions belong together. However, evangelicals admonish the ecumenicals not to replace eternal salvation with secular welfare. Conversely, the ecumenicals warn the evangelicals not to neglect social ethics by focusing only on eternal salvation.[21]

19 Cf.: Frieling, Weg 273; Holthaus, Mission 42; Werner, Mission 67
20 Frieling, Weg 276f
21 Ibidem 276f

2.3 The WCC Studies about "The Missionary Structure of the Community"

At the third plenary assembly of the Worl Council of Churches in New Delhi in 196 the IMR was integrated into the WCC. Th organizational shift emphasized what ha become apparent through the approach o the Missio Dei. In essence, church an missions belong together since the churc as a whole is missionary.

Under the direction of Jochen Margull study project addressing "The Missiona Structure of the Community" was begun New Dehli in 1962 to characterize the mi sionary character of the church. Margu was influenced by Hoekendijk and his hi tory of promise model of missions. The was a wide interest in this study and sever international working groups were esta lished to facilitate its completion.

In 1965, Margull published the worl book "Mission as Structural Principle." 1967, the WCC then publicized the final re ports of the West European and Nort American work groups in a publication en titled "Church for Others and Church fo the World Struggling to Find Structures fo Missionary Communities."

These two publications have severa points in common. First, history and th world as a whole are under the influence o the Missio Dei. The direction of movemen is God—World—Church.[22]

22 Cf. Kirche für andere 16

Second, the world is considered positively. The church and the world are not confrontational enemies, but the church is "part of the world loved by God and to which he reveals his love."[23]

Third, conversion in the traditional view means to turn away from the world, but now conversion means "to turn to the world in hope."[24]

Fourth, the aim of missions is not above all growth of the church in quantitative terms, but missions is understood in messianic terms as the aim to preach and embody the liberating acting of God (the Gospel) in reconstructing the kingdom while offering "peace and salvation."[25] The notions of "shalom" and "humanization" in the sense of a liberation of true humanity are introduced into the discussion about the aim of missions.[26] The notion of shalom emphasizes that salvation and welfare belong together. Thus, isolationism and retreat from the world is excluded from Christian missions.[27] With this conception of the aim of the church, these publications justify Bonhoeffer's programmatic statement that "church is only church when it is there for the other".[28]

Finally, not only pastors and professional missionaries but also lay people are responsible for Christian missions. "It is indeed the lay man who is qualified to be the missionary of our time."[29]

23 Ibid. 14
24 Ibid. 14
25 Hoekendijk in: Mission als Strukturprinzip 33
26 See: Kirche für andere 17.89
27 Werner. Mission 97
28 Ibid. 94
29 Kirche für andere 28

These studies published by Margull and the WCC represent a turning point in the comprehension of Christian missions from the history of salvation model to the history of promise model.

2.4 The Ecumenical-Evangelical Controversy

2.4.1 "Look, I Have Been Creating Everything Anew – The Plenary Assembly of the World Council of Churches in Uppsala in 1968

The interpretation of missions as outlined in the WCC study of "The Missionary Structure of the Community" had a decisive influence on the fourth WCC plenary assembly, which was held in Uppsala in 1968 under the banner "Look, I Have Been Creating Everything Anew."

At this conference, the document "Renewal of the Mission" caused violent discussions, and the conflict between ecumenicals and evangelicals became apparent to a broader public for the first time. This document envisions "an anthropological change in the interpretation of missions" due to the confession that Christ is the "true" or the "new man." This document mentions shalom and humanization of society as missionary aims in accordance with the structural study.[30] Missions should open itself to the world. The formulation "the world determines the order of the day" has become commonplace since Uppsala. The world is the place where the credibility and significance of the Gospel is revealed.[31]

30 Werner, Mission 111
31 Grundmann, Welt 132

In Uppsala, John Stott, speaker of the evangelicals within the Church of England, represented the evangelical position. He thought that the WCC was so anxious about physical hunger that it did not take the spiritual hunger of humanity into consideration.

After the conference, the missionary theologian Peter Beyerhaus formulated the evangelical criticism on Uppsala in his book "Humanization – Only Hope in the World?" He stated, "There has been a fundamental ecumenic-evangelical confrontation before and after Uppsala."[32]

2.4.2 Missions as Liberation: The Missionary Conference in Bangkok in 1973

The 1960s were characterized by optimism in technical and scientific progress and confidence in improving the world situation by human efforts. In the 1970s, this positive view of the world was subdued because of increasing social conflicts and crises.

This background shaped the world mission conference in Bangkok in 1973. The theme of this conference was "Salvation of the World Today." This conference is important for the understanding of missions because an "integrative comprehension of salvation" was developed. This integration was mainly elaborated in a document entitled "Salvation and Justice."

In this document, the integrative comprehension of salvation is formulated as follows: "We think that salvation means renewal of life-development of true human in the fullness of God (Col. 2,9). It is salv tion of the soul and of the body, of the in vidual and the society, of mankind and t 'sighing creature' (Rom 8,19). ... We mu overcome in our thoughts the splitting b tween soul and body, man and society a mankind and creation. That is why we co sider the fight for economic justice, poli cal freedom and cultural renewal as el ments for a complete liberation of t world in the name of God."[33]

Whereas humanization had been a leit motif in previous meetings of the WCC salvation as well as missions was at the center of discussion in Bangkok. The integrative meaning of salvation marked "the beginning of a social hermeneutics of salvation" (H. J. Margull) and consequently led to a change in the interpretation of missions. The trend was towards missions as empowerment to liberation.[34]

This trend related to the Latin America theology of liberation that was so importa in the Roman Catholic Church at that time.

Evangelicals seriously criticized this vie of salvation elaborated in Bangkok. The mo important representative of the evangelica in Bangkok was Peter Beyerhaus. In reflec ing of the conference, he stated that the un derstanding of salvation and missions was no informed by biblical but by syncretistic an socio-political notions.[35] The difference be tween evangelicals and ecumenicals had be come more obvious and seemed to be irrec

32 Beyerhaus, Humanisierung 46ff

33 See: Werner, Mission 200
34 Werner, Mission 201
35 Hering, Missionsverständnis 123

oncilable for some people. A representative of the WCC remarked at that time, "You are either evangelical or a friend of the WCC."[36]

2.5 The Lausanne Covenant (1974)

After the conference in Bangkok, many evangelical missionary groups kept their distance from the WCC and its interpretation of missions. The evangelical movement gained in strength under the influence of such powerful speakers as Billy Graham, John Stott and Donald McGavran.

Following several evangelical congresses, about three thousand evangelicals from over 150 countries met in Lausanne in 1974 for a congress about world evangelization. This congress was initiated by Billy Graham, and its theme was "Let the Earth Hear His Voice." The result of this congress is the "Lausanne Covenant," which became the most important document for the understanding of missions in the evangelical movement.

The "Lausanne Covenant" consists of fifteen items, but only items five and six are relevant for the present essay.

Item 5 recognizes the social responsibility of Christians and reads, "We ... express penitence ... for having sometimes regarded evangelism and social concern as mutually exclusive. Although reconciliation with other people is not reconciliation with God, nor is social action evangelism, nor is political liberation salvation, nevertheless, we affirm that evangelism and socio-political involvement are both part of our Christian duty. For both are necessary expressions of our doctrines of God and man, our love for our neighbour and our obedience to Jesus Christ."

Item 6 emphasizes the priority of evangelization in its formulation, "In the Church's mission of sacrificial service evangelism is primary." This item also affirms, "World evangelization requires the whole Church to take the whole gospel to the whole world."

Preference for the term "evangelism" over the term "missions" in the Lausanne Covenant raises the question of the relationship between evangelism and missions. John Stott answered this question by stating that the term "mission" is used in a larger sense and includes evangelism in the sense of propagation but that evangelism cannot be identified with propagation.37 Earlier at Uppsala, Stott already articulated this larger understanding of missions when he said, "Mission is equal to propagation plus service." Thus, the evangelical movement confirmed that social and political commitment is a genuine Christian task of evangelism and recognized missions as a more comprehensive endeavor than evangelization. The vertical and horizontal dimensions of missions belong together even though the priority is given to evangelization.38

2.6 The Larger Interpretation of Missions: The Fifth Plenary – Assembly of the World Council of Churches in Nairobi in 1975

The Lausanne Covenant brought evangelicals and the WCC back together again so that at the fifth plenary assembly in Nairobi, evangelicals and ecumenicals were conversing once again.

36 See: Hering, Missionsverständnis 125
37 Ibid. 129

38 Cf.: Hering, Missionsverständnis 127-130; Sautter, Heilsgeschichte 246-250

The broader understanding of missions or the "comprehensive understanding" was expressed by Bishop Mortimer Arias in a speech in Nairobi. He stated:

> "True evangelism in comprehensive: all the Gospel for all mankind and man as a whole. The recipient of evangelism is man in his wholeness: in his individuality and sociality, in body and spirit, in time and timelessness. That is the reason why we reject all attempts of the present and the past to divide man and attempts to reduce the Gospel to a single dimension and attempts to divide man who is the image of God. We reject the opinion that evangelization means only to save souls and is an exclusive search for a better hereafter for each individual, because it is not sufficient in the biblical sense. Neither do we accept that the Gospel is simply reduced to a programme of service and social development or to a simple tool of socio-political concepts (Mt 9,35-38; Lk 4,18-19; Acts 16,31; 1Tim 4,6-10; 2Tim 1,10)."[39]

John Stott as a representative of the evangelicals completely accepted Bishop Arias' statement.

2.7 Mission from the Perspective of the Periphery: The Missionary Conference in Melbourne in 1980

The missionary conference in Melbourne in 1980 adopted the theme "Your Kingdom Come." This conference had to consider several developments on the world scene. The disparity between industrial nations and third world nations had increased and the dialogue between them had fall silent.[40]

In this global context, the contribution missions to the creation and maintenan of dominant power constellations becam increasingly apparent.[41]

These developments of the world scen had important consequences for the confe ence in Melbourne, which transformed th motto of the 1960s "Church for Others into an ecclesiological programme. Th conference concluded:

> "The Church of Jesus Christ must be a church of the poor (and not simply a church for the poor)."[42]

Missions should happen from the "per spective of the periphery" – the powerfu mission on the top should be changed t the mission practice from the bottom.[43]

In Christological terms, the understand ing of missions changes in Melbourne fron a theologia gloriae that stresses the imag of an elevated and triumphant Christ to theologia crucis oriented toward the earthl life and death of Jesus and stressing th identification of both God and Jesus with the poor, with those who suffer, and with those who are condemned and helpless and powerless.[44]

In its understanding of missions, the conference in Melbourne naturally referred

39 See: Hering, Missionsverständnis 5

40 Werner, Mission 128-130
41 Ibid. 129
42 Ibid. 130
43 Ibid. 225
44 Ibid. 131f

frequently to the Latin American liberation theology.

2.8 Mission and Evangelism – An Ecumenical Affirmation (1982)

In 1976, one year after the plenary assembly of the WCC in Nairobi, the central committee of the WCC instructed the Commission for World Mission and Evangelization (CWME) to draft a declaration about missions and evangelism. All member churches of the WCC were asked to explain the essence of their missionary work. On the basis of these statements, the CWME drafted an ecumenical declaration and presented it in 1981 to the central committee, which passed it in 1982. This first official declaration of the WCC with regard to the interpretation of missions reflects the contributions of the churches as well as the results of the assemblies in Nairobi and Melbourne.

The document "Mission and Evangelism" (ME) was broadly accepted by the ecumenical movement. Currently, this document is the most important statement about the understanding of missions within the ecumenical movement.

This document refers to Jn 20,21 and Acts 1,8 and justifies the missionary character of the church in the sense of the Missio Dei approach by confessing, "The church has as one constitutive mark its being apostolic, its being sent into the world" (paragraphs 7-8). For that reason, the proclamation of the Gospel includes solidarity with the poor.

ME expressively emphasizes both the vertical and the horizontal dimensions of the Gospel by declaring, "The spiritual Gospel and the material Gospel were in Jesus one Gospel" (paragraph 33). The aim of missions is conversion (paragraphs 10-13) as well as "the multiplication of local congregations in every human community" (paragraph 25). ME stresses "mission in six continents," the statement of the missionary conference in Mexico City, and explains, "Everywhere the churches are in missionary situations" (paragraph 37).

ME bridges the gap between ecumenicals and evangelicals. The long period of polarization had come to an end.

In the 1990s, some member churches of the WCC expressed their wish to development a new declaration about missions and evangelization that would not replace ME but continue it.[45] An initial consultation for a new declaration of missions gathered in San Salvador in 1996.[46] Before the plenary assembly of the WCC occurred in 1998 in Harare, a draft for a complementary declaration was completed but not presented to all the member churches and councillors of the WCC before the assembly. This procedure and the criticism of the draft declaration by some members were the reasons why this declaration did not find acceptance. Hence, ME continues to form the basis for the understanding of missions in the WCC.[47]

2.9 The Trinitarian Approach to the Missio Dei: Canberra 1991

Before and after the WCC plenary assembly in Canberra in 1991, the interpretation of Missio Dei was discussed again with regard to the inter-religious dialogue (see 4.2). The theme of the Canberra Meeting

45 Linn, Vollversammlung 187
46 Zu einer Hoffnung berufen 60
47 Linn, Vollversammlung 186-189

was "A New Interpretation of the Prerequisites of the Missio Dei with Regard to the Trinitarian Theology."

In this meeting, the model of the history of promise was extended beyond the Christological and ecclesiological understanding of Missio Dei to a pneumatological understanding. Arising from Trinitarian theology, the underlying question was formulated before Canberra as follows: "The question is whether the Father is the only source of the spirit or together with his Son. If the latter is the case, then the flowing of the Spirit is limited to Christian channels and more particularly to the church. The rest of humankind can only experience the Spirit through the intervention of the church. If the former is the case, then the starting point from which the spirit blows freely through the oikoumene is more vast and comprises the neighbours of the other faiths as well."[48]

In the pneumatological understanding of missions, the missions of the church consequently cannot be "God's only mission." Missions then is only part of the worldwide mission of the Lord's Spirit who has the freedom to influence other religions in movements and communities outside the church.[49]

Great expectations flowed from the WCC plenary assembly at Canberra. Some people hoped that concentrating on the theme "Come, Holy Spirit – Renewing All Creation" would bring the complete Trinitarian perspective of church and missions into vogue and open a new chapter of ecumenical history.[50]

48 Werner, Mission 425
49 Ibid. 426
50 Ibid. 445

These expectations were not realized however, and full realization of the Trinitarian theology in the Missio Dei approach is part of the future work of missions theology.

2.10 The Declaration of the Lutheran World Federation: God's Mission as Common Task – A Contribution of the LWF to the Understanding of Missions (1988)

The LWF's declaration will not be presented in its entirety. Instead, relevant statements are excerpted that focus on some significant aspects of missions theology.

In the first chapter entitled "Theological Statements to Mission from a Lutheran Point-of-View," the Missio Dei is the starting point. "God is a God of mission. The sending of his Son and the Holy Spirit into the world was the highest expression of the Godly missionary effect" (1.1). The declaration refers expressly to the Trinity. "The mission of God is considered in this document with relation to the term Trinity. ... The radius of the Godly mission cannot be understood by man" (1.2). "The mission of the Church is deduced from God's own mission. God's own mission is larger than the mission of the Church" (1.3).

The primary aim of mission is conversion "to convert all peoples to disciples" (1.3). In 4.1.6, mission is described holistically, "All the ecclesiastical propagation must express the wholeness of mission by unifying word and deed. ... The word without deeds corresponding to it falsifies the word itself. On the other hand, when the deed is not accompanied by the word, there is the danger to lapse into pure humanity."

Other parts of the declaration emphasize he importance of social action. "An integral part of mission ... is to work for freedom and justice" (1.3). Missions must face challenges caused by poverty, and the churches must be "present there where the poor are" for reasons of credibility" (3.4.5). Christologically, missions is oriented towards Jesus Christ, who became human and died on the cross. Missions has to propagate the crucified Christ, and therefore "triumphalism is in contradiction to God's own mission" (4.1.10).

There is significant agreement in the understanding of missions in the Lutheran World Federation and in the document Mission and Evangelism of the WCC. An important difference, however, is that the Missio Dei approach is interpreted in ME christologically but in the LWF declaration theologically with special emphasis on Trinitarian theology.[51]

3 The Understanding of Missions in the Roman Catholic Church

Section 3 of this essay presents the development of the understanding of missions in the Roman Catholic Church by discussing educational missions texts beginning with the Second Vatican Council from 1962 to 1965 and later.

3.1 Tendencies in Missions Theology before the Second Vatican Council

At the beginning of the 20th century, two different tendencies were present in the Roman Catholic understanding of missions.

J. Schmidlin founded the Munster school and emphasized the soteriological center of missions. For him, missions means evangelization with the aim of saving souls and of converting people.

In contrast, P. Charles of the Leuwen School placed ecclesiology at the center of missions. For him, the aim of missions is the plantatio ecclesiae, which means that the Church is "implanted" among non-Christians by establishing the institutions of the Church.

3.2 The Missions Theology of the Second Vatican Council

The Second Vatican Council specifically addressed the missionary activity of the Church in a decree called "Ad gentes." Other decrees, however, also contain important statements about the understanding of missions, especially the dogmatic constitution "Luman gentium." In these documents, the ecclesiology of the Church forms the basis for the understanding of missions.

The church is no longer exclusively considered as a hierarchical institution but as a sacramental reality. "The Church, in Christ, is in the nature of sacrament – a sign and instrument, that is, of communion with God and of unity among all men" (LG 1).

The sacramentality of the Church is interpreted in two ways. On the one hand, Church is a sign for the relationship to god and the unity of humankind. On the other hand, Church is an instrument that has a responsibility toward the world.[52]

51 Cf.: Holthaus, Mission 42f

52 Rahner, Konzilskompendium 106

The missionary character of the Church is a constitutive component of the church as a sacramental reality. The missionary character of the Church is explicitly exposed in the mission decree of the Second Vatican Council. "The pilgrim Church is missionary by her very nature, since it is from the mission of the Son and the mission of the Holy Spirit that she draws her origin, in accordance with the decree of God the Father" (AG 2). The basis of the Church's missionary character is Trinitarian. Before the Council, the Church was the sender, but after it the Church is the one sent from God into the world.[53] The parallels to the Missio Dei approach are apparent.

Since the Council describes the Church as "God's people" (LG 9-17), every baptized person participates in the mission of the Church. Each Christian is a missionary and has to fulfill her or his task of being sent (cf. LG 17; AG 35.36).[54]

Important for the Council's understanding of missions are also the elevation of the churches in each country and the teaching of the bishops' collegiality. The Church consists of different national churches (cf. LG 23), and the bishops are authorized to be the leaders of their national churches. The Western or "mother Church" is no longer the head of the "offspring churches." On the contrary, the churches form a brotherly community. Karl Rahner says, "The Second Vatican Council and its first trial to find itself may be considered as the first official self-achievement of the Church as world church."[55]

This understanding breaks open ecclesiastical centralism but leaves unclear how the primacy of the Papacy can be combined with this plurality of the Church.[56]

According to the Council, the task of missions are "Preaching the Gospel and planting the Church among peoples or groups who do not yet believe in Christ" (AG 6). By stating the aim of missions this way, the Council tries to synthesize the two tendencies in missions theology before this decisive Council occurred.

The targets of missions are "peoples and communities," and thus missionary activity is described geographically, sociologically and anthropologically.[57] This view corresponds to the comprehension of "mission in six continents" espoused by the missionary conference in Mexico City in 1963.

Rahner speaks in this context of a "planetarian diaspora" and means that there are no longer so-called "Christian countries."[58]

A further new understanding of mission marks the conciliar confession to God's general salvation that encompasses the non-Christian world. "The Savior wills all men to be saved (cf. 1 Tim 22,4). Those who through no fault of their own, do not know the Gospel of Christ or his Church, but who nevertheless seek God with a sincere heart and, moved by grace, try in their actions to do his will as they know it through the dictates of their conscience – those too may achieve eternal salvation" (LG 16; cf. AG 7). God's influence is also outside the church

53 Glazik, Mission 157
54 Üffing, Kirche, 32; cf. also LG 17; AG 35f
55 Üffing, Kirche 20f
56 Cf. Collet, Missionverständnis 116f
57 Üffing, Kirche 33f
58 Collet, Missionsverständnis 63 (note 27)

and God offers salvation to all humans. This understanding is very similar to the salvation history model of the Missio Dei approach.

3.3 The Development of the Roman Catholic Understanding of Mission after the Second Vatican Council

3.3.1 The Apostolic Letter "Evangelii nuntiandi" (1975)

The understanding of missions is continued in Pope Paul VI's apostolic letter "Evangelii nuntiandi" (EN).

According to EN, "evangelizing" is "the essential mission of the Church" (EN 14). The Church evangelizes in the succession of Jesus, who was sent by the Lord (EN 6,7). Here missions is not grounded in Trinitarian theology as at the Council (AG 2) but in the historical Jesus.

EN defines "evangelizing" as "bringing the Good News into all the strata of humanity, and through its influence transforming humanity from within and making it new" (EN 18). Thus, EN defines "evangelizing" in terms "of proclaiming Christ to those who do not know him" (EN 17).

The aim of evangelization is qualitatively an inner change and quantitatively "preaching the gospel in ever wider geographical areas or to greater numbers of people" (EN 19). At several places (EN 8,9,34) EN mentions the propagation of God's kingdom with regard to the continents and clearly stresses liberation theology. The targets for evangelization are not only non-Christians but also "baptized people, who no not practice" (EN 21). So EN envisions a global situation of missions.

Significantly, EN addresses the relationship between propagation and social action. This question can be seen in connection with the development of the ecumenical movement. EN refers to social action by using terms such as "development" and "liberation." EN 31 reads, "Between evangelization and human advancement—development and liberation—there are in fact profound links." Both aspects should be taken into account. On the one hand, the mission of the Church may not be limited by an anthropocentric refusal to consider the religious dimension of the human being, his or her "openness to the absolute, even the divine Absolute" (EN 33) or by replacing the "proclamation of the kingdom by the proclamation of forms of human liberation" (EN 34). In this context, EN speaks of the "primacy of the spiritual vocation" (EN 34). On the other hand, mission should not be reduced "in a religious way" since "it must envisage the whole man, in all his aspects" (EN 33). "The Church is ... not willing to restrict her mission only to the religious field and dissociate herself from man's temporal problems" (EN 34).

So, EN develops a broader understanding of missions and searches for a balance between the vertical and the horizontal dimensions of missions.[59]

3.3.2 The Encyclical Letter "Redemptoris Missio" (1990)

Twenty-five years after the end of the Second Vatican Council and fifteen years after the publication of "Evangelii nuntiandi," Pope John Paul II published the encyclical letter "Redemptoris missio" (RM). Its theme is the continued validity of missions.

59 Cf. to EN: Collet, Missionsverständnis 124-132; Müller, Missionstheologie 37f

Admitting that "missionary activity specifically directed 'to the nations' (ad gentes) appears to be waning," the encyclical letter emphasizes the "urgency of missionary evangelization" (RM 2). Missionary activity should "push forward to new frontiers" (RM 30). RM describes the following tendencies in the Roman Catholic understanding of missions.

RM generally has a positive view of missions and recognizes the shift from western missions to world missions. Nevertheless, it reintroduces some old inequities with statements such as the following: "To say that the whole Church is missionary does not exclude the existence of a specific mission ad gentes, just as saying that all Catholics must be missionaries not only does not exclude, but actually requires that there be persons who have a specific vocation to be 'life-long missionaries ad gentes'" (RM 34). This statement alludes to the old geographic view of missions and assigns a position of prominence to the Western Church that was avoided in the Second Vatican Council.[60]

According to RM, the goal of missions is both to convert the lost and "to found Christian communities and develop churches to their full maturity" (RM 48). Faith in Christ is understood as "directed to Man's Freedom" (RM 6), but it is emphasized that "there is one mediator between God and men, the man Jesus Christ" (RM 5) and "that the Church is the only way of salvation and that she alone possesses the fullness of the means of salvation" (RM 55). Such statements make the inter-religious dialogue difficult.[61]

60 Cf.: Collet, „Redemptoris Missio" 163; Waldenfels, Ekklesiologie 181f
61 Cf. Evers, Dialog

RM also comments on the relationship between evangelization and social obligations. It attaches special importance to the danger of reducing salvation and missions to the social dimension alone. "There are ideas about salvation and mission which can be called 'anthropocentric' in the reductive sense of the word, inasmuch as they are focussed on man's earthly needs. In this view the kingdom tends to become something completely human and secularized; what counts are programs and struggles for a liberation which is socio-economic, political and even cultural, but within a horizon that is closed to the transcendent. ... The kingdom of God, however, 'is not of this world ... is not from the world." (Jn 18,36; RM 17).

By rejecting the limitation of salvation to the horizontal dimension, RM distances itself from the Latin American liberation theology. At the same time, RM stresses that "action on behalf of integral development and liberation from all forms of oppression is most urgently needed" (RM 58). Thus, it refuses to limit salvation to the vertical dimension.[62] RM narrows somewhat the understanding of missions as a worldwide mission and retreats from the broad understanding of missions that envisions every land and people in need of missionary activity.[63]

3.4 Karl Rahner's Theory of the "Anonymous Christ" and Its Effect on the Understanding of Missions

Karl Rahner's theory of the anonymous Christ is of great importance for the understanding of missions in the Roman Catholic Church. His theory has two presuppositions.

62 Cf. Collet, „Redemptoris Missio" 171-174
63 Ibid. 174f

First, Rahner favors an anthropology that sees human beings as a unity of spirit and matter. He supposes that a human in his or her spirituality has always been related to God, the absolute being. Rahner states, "Man is spirit, that means he lives his life in a permanent stretching to the absolute, in an openness for God." "He is man simply because of the fact that he has always been on the way to God, whether he knows it explicitly or not, whether he wants it or not, because he is always the unending openness of the finiteness for God."[64] The human orientation to God is always there regardless if a human realizes it or not. Humans always have to do with God when they meet their own fellow humans and in their encounter with their surroundings in general.

Second, Rahner stresses the general salvation will of God as a second presupposition for his theory (cf. 1Tim 2,4). God desires healing for all people and offers it to everyone.

The theory of the anonymous Christ holds that a person who has never been confronted with the Christian verbal revelation is able to believe. Such a person is not a Christian in an explicit and confessing manner but in an implicit anonymous way. According to Rahner, persons are believers when they affirm themselves, when they follow their conscience, when they practice faith, hope and love.[65]

It is important to know that an anonymous Christian is exhorted to become explicitly and consciously a Christian when he is confronted with the Christian message. Being an anonymous and confessing Christian cannot be considered as two equivalent forms of being a Christian. Being an anonymous Christian leads to becoming a confessing Christian. According to Rahner's theory, non-Christian religions can be legitimate ways of salvation for humans.

Several critics of Rahner's theory stress that it undermines the missionary efforts of the Church. Why should a person become an explicit Christian when that person can find God's blessing as an anonymous Christian?66 These criticisms assume that Rahner considers Christianity as well as non-Christian religions as equivalent ways of salvation. He does not, however, and holds that Christian missions has an important task since it aims at the transformation of an implicit Christian into an explicit Christian. Rahner thinks his theory provides a basis for missions. Missions can only be effective when there is a sensibility for the Christian message, and this sensibility is an inner orientation to God. Thus, Rahner's theory of the anonymous Christ is important for understanding Christian missions.67

4 Materialization

4.1 The Relationship between Christianity and the Non-Christian Religions

Everyone who attempts to understand missions encounters the question of how to define the relationship between Christianity and other religions. Three different models explaining the possible relationships have

64 Rahner, Hörer 86
65 Cf.: Bernhardt, Absolutheitsanspruch 174-187; Jäger, Heilsmöglichkeit 161-217; Sievernich, Aktualität 196
66 Cf. Bernhardt, Absolutheitsanspruch 195
67 Sievernich, Aktualität 196; cf.: Rahner, Schriften VI 485-488

emerged since the 1980s. Each model represents different understandings of missions or missionary paradigms.

The first model is **the model of exclusivism**. According to this model, "among all religions only Christianity possesses the perception of God or His revelation in the sense of salvation."[68] This model represents Christianity alone as seeking universal truth and all other religions as being on the wrong track. Disciples of non-Christian religions can only be saved through conversion to Christianity. Christian missions is in Karl Barth's words "the announcement of light within darkness."[69]

The second model is the **model of inclusivism**. According to this model, "among all religions, Christianity does not possess the only perception of God or His revelation in the sense of healing. But the difference is that Christianity possesses it in a form superior to all other religions."[70] This model allows that other religions possess their part of the truth but affirms that Christianity alone is in abundant possession of the truth. Missions can start with any tradition of a religion and continue from that point to lead the adherents of these other religions to the fullness of salvation in Christianity. This model of inclusivism is the basis for Karl Rahner's theology and his understanding of missions.[71]

The third model is the **model of pluralism**. According to this model, "among all religions, Christianity does not exclusively possess the perception of God and His revelation in the sense of salvation. The understanding of God and His revelation are, even in their relatively highest form part of other religions besides Christianity."[72] This model abandons the demand for Christianity as the universal truth. The conversion to Christianity can no longer be a direct dim of missions when all the other religions are considered equally legitimate means of salvation. Christian missions occurs within the inter-religious dialogue as "a mutual giving and taking an interest in the different dimensions of human affectedness of the last reality as well as an inter-religious cooperation by encouraging the humane. Here conversions do not take place from one religion to another but within every religion in the sense of leading a more perfect life according to one's own proper religious tradition."[73] In this sense, one can speak of "mutual" or "multilateral" mission. One lingering question raised by this model is whether or not missions can "affirm other religions as ways of salvation without giving up one's own identity and truth."[74]

4.2 Mission and Dialogue

Since the mid-sixties, the theme "mission and dialogue" has become an important topic in the discussions about missions in the World Council of Churches and the Roman Catholic Church. Today, it is impossible to conceive of missions without engaging in a dialogue with the recipients of the message.[75] This dialogue became necessary for two reasons. First, the rise of a global consciousness with its conception of a worldwide network

68 Schmidt-Leukel, Grundmodelle 232
69 Peter, Missionsverständnis 383
70 Schmidt-Leukel, Grundmodelle 233
71 Peter, Missionsverständnis 384
72 Schmidt-Leukel, Grundmodelle 234
73 Peter, Missionsverständnis 384f
74 Ibid. 386
75 Wrogemann, Mission 135

of economics, media, and technology necessitates this dialogue.[76] Second, the recognition of other religions as possible paths to salvation and the respect shown these religions by both Protestants and Roman Catholics makes such a dialogue necessary. Responsible dialogue requires that the missionaries take seriously the beliefs and religious doctrines of those they serve.[77]

Hans-Werner Gensichen distinguishes among three models that explain the relationship between mission and dialogue.

The first model is the **model of polarity**. In this model, mission and dialogue have nothing to do with one another.

The second model is the **model of subordination**. In this model, the dialogue simple becomes the means to realize the aim of Christian missions. For example, Peter Beyerhaus holds that the non-Christian religions are human contacts with demonic powers that take all power away from their adherents. Therefore, dialogue is only legitimate when it aims at the conversion of those with such beliefs. In this sense, the dialogue is acknowledged as a "form of missionary contact" in the Frankfurt declaration.

The third model is the **model of complementarity**. In this model, missions and dialogue influence and correct one another. In the dialogue, one's own identity becomes comprehensible by listening and speaking to the other. Dialogue in this model is a reciprocal process of learning and is not simply confession but seeking the truth.[78]

76 Ibid. 137
77 Ibid. 268
78 Ibid. 144f

4.3 Enculturation

Originating from Jewish Palestine, Christianity early encountered other cultures and developed an enormous cultural adaptability. In this encounter, elements of other cultures were adopted, reinterpreted, or rejected. In the course of time, however, Christianity became more structured and rigid and eventually became closely identified with occidental culture. This identification hindered Christianity's advance in other cultures. The advanced civilization of the occidental world and the "Eurocentric mentality of superiority"[79] prohibited Christianity from mutual interaction with other cultures. Thus, the "cultural missions" of the 19th century brought the gospel and occidental culture simultaneously to non-Christian peoples.

In the 20th century, however, people became sensitive to the exportation of Western culture. A slow and difficult liberation of the church from its occidental cultural trappings ensued. This multifaceted process is described as acculturation, adaptation, accommodation, indigenousation, contextualization, or enculturation. All these terms express the desire to give each culture the possibility of formulating and fashioning the Christian faith in ways appropriate to that culture.

There are different understandings of enculturation. A. Roest Crollius defines it as the "integration of the Christian experience of a local church into the culture of the people in question in such a way that this experience does not only express itself in elements of one's own culture but also becomes a power which makes this culture alive, gives it direction and renews it. In this

79 Piepke, Evangelium 12

way, a new unity and community is created, not only within the culture in question but also in the church as a whole."[80]

Evangelization or missions always happens – and this is what Crollius' definition clarifies – within cultural ideology and is a mutual event. Leonardo Boff says, "The Gospel shows itself in the guise of a particular culture."[81] The Christian faith finds its expression in the culture of a people without opening itself to the cultural forms of thinking and living; enculturation occurs in the "tension of proximity and distance of the Gospel to the cultures."[82]

These different understandings of enculturation are important for the Roman Catholic as well as the Protestant theology of missions at the beginning of the third millenium. The starting point for the apostolic letter "Evangelii nuntiandi" and the encyclical "Redemptoris Missio" is enculturation. For example, RM 54 reads,

> "Through enculturation the Church makes the Gospel incarnate in different cultures and at the same time introduces peoples, together with their cultures, into her own community. She transmits to them her own values, at the same time taking the good elements that already exist in them and renewing them from within."

With regard to ecumenical missionary theology, the relationship between the Gospel and culture have been talked about repeatedly.[83] This theme was the main topi on the agenda of the 11th World Missio Conference in Salvador da Bahia in 1996 The theme of this conference was "Destine for One Hope – The Gospel in Different Cul tures." The message sounding from thi conference was "We sincerely hope that thi last mission conference in this century ha made plain that the Gospel must remain it self if it wants to bear fruit and at the sam time it must be part of a culture or rooted in it."[84]

5 Summary

In his book "*Transforming Mission Paradigm Shifts in Theology of Mission*" David Bosch presents the shift in the understanding of missions in the history of theology. He speaks of a "*post-modern paradigm*" of the theology of missions. The present essay has addressed this paradigmatic change that has occurred and continues to occur in the understanding of missions both in the Protestant and Roman Catholic churches. This section of this essay summarizes the points investigated and clarifies the areas of conflict in which discussions of missions take place.[85]

1. Christian missions is no longer understood ecclesiocentrically as an activity starting from the churches to save souls and found churches. Missions is anchored in the doctrine of trinity and is a characteristic of God, who is a sending God. God sends the Son and the Holy Spirit, and **missions is founded in the Missio Dei**. All human mission is part of

80 Üffing, Kirche 235
81 Reliprax 14
82 Ibid.

83 Cf.: Werner, Mission 265-381
84 Zu einer Hoffnung berufen 115
85 Cf.: Bosch, Mission 349-351; Gensichen, Akzente 113; Werner, Mission 44-47

the Missio Dei, and every Christian has a missionary task. The Missio Dei approach was and is understood in various ways.

Two models may be distinguished:

- The **history of salvation model** affirms that God sends Jesus and the sending of Jesus continues in the sending of the church. The histories of the world and of salvation are two different and separate things. Salvation is given to the unredeemed world through the church.
- The **history of promise model** interprets the Missio Dei approach in a broader sense. It affirms that God has saved the whole world through Christ and that God's mission exceeds the borders of the visible church. This model lays the foundation for a Christian's being directed towards the world. An extension of this model to Trinitarian theology leads to a pneumatological understanding of missions. God's Spirit starts directly from the Father and not only through the mediation of the Son. That is why God's Spirit also has an effect not only inside the church but also outside the church as well. The extent of the influence of God's spirit and as such of God's mission is larger than the extent of the Christian church.

A tension between the two understandings of the Missio Dei caused the **ecumenical-evangelical controversy** with regard to the understanding of missions. This controversy is fueled by the **tension between the vertical and horizontal dimensions of missions** that distinguishes between word and deed, between the preaching of the Gospel and Christian social service, between testimony and service, between orthodoxy and orthopraxy, and between church and world. Both the vertical and horizontal dimensions are essential for an integrative, holistic understanding of missions, but the controversy over and the discussions about these two dimensions has by no means come to an end.

Klaus Schaefer relates evangelization and church social service when he says: "When we distinguish between evangelization and church social service, these two dimensions of the mission of the church in the world may not be considered separately. Missionary preaching is – to quote David J. Bosch – the 'heart' of mission, but evangelization and church social service are related to one another and will continue to be related. They compliment one another; they correct one another; they are a credible testimony of the church being part of God's mission by means of this unsolvable interplay; and which is directed to the salvation of the whole creation. ... The most important thing about this unsolvable interplay is that the credibility of the church's acting is at stake."[86]

2. In the seventies, solidarity with the poor became very important. In the eighties, the poor are no longer considered as recipients or objects of missions but the true bearers of missions as subjects. This change corresponds to the shift in the paradigm of **missions from the perspective of missions in the center to missions in the periphery.**

3. Recognizing the tension between missions and culture, Christians have finally accepted the cultural identity of non-Western peoples and churches. Missions is no longer a "cultural mission" but an **encul-**

86 Schäfer, Mission 271

turation of the Gospel. This development results in a "cultural polycentral structure of the world church."

4. The issue of the **relationship between Christianity and other religions** is controversial. Three basic models illustrate this controversy:

- The model of **exclusivism** illustrates that "among all religions only Christianity possesses the perception of God or His revelation in the sense of salvation."
- The model of **inclusivism** holds that "among all religions Christianity does not possess the only perception of God or His revelation in the sense of healing. But the difference is that Christianity possesses it in a form superior to all other religions."
- The model of **pluralism** communicates that "among all religions, Christianity does not exclusively possess the perception of God and His revelation in the sense of salvation. The understanding of God and His revelation are, even in their relatively highest form, part of other religions besides Christianity."

5. Three models help explain the various possibilities of the relationship between missions and the dialogue of Christianity with other religions:

- The model of **polarity** recognizes no relationship between Christian missions and dialogue with other religions.
- The model of **subordination** presents dialogue merely as an instrument to attain the conversion of those of other faiths.
- The model of **complementarity** presents dialogue with other religions as an important aspect of missions. According to this model, missions and dialogue influence and correct one another. In the dialogue, one's own identity becomes comprehensible in the listening and speaking with the other. The aim of dialogue is finding the truth by a reciprocal process of learning.

6 Conclusion

This essay has briefly described the shift in the understanding of missions in the 20th century. It has attempted to explore the various and complex issues involved in understanding missions. In responding to these issues, Christians should realize they are part of the Missio Dei, of God's own mission.

Christian missions means participating in God's salvation activities in the world.

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